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Berkeley, California

Kaiser Permanente Medical Care Program Oral History Project

Wilbur L. Reimers, M.D.

HISTORY OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

An Interview Conducted by
Malca Chall
1986

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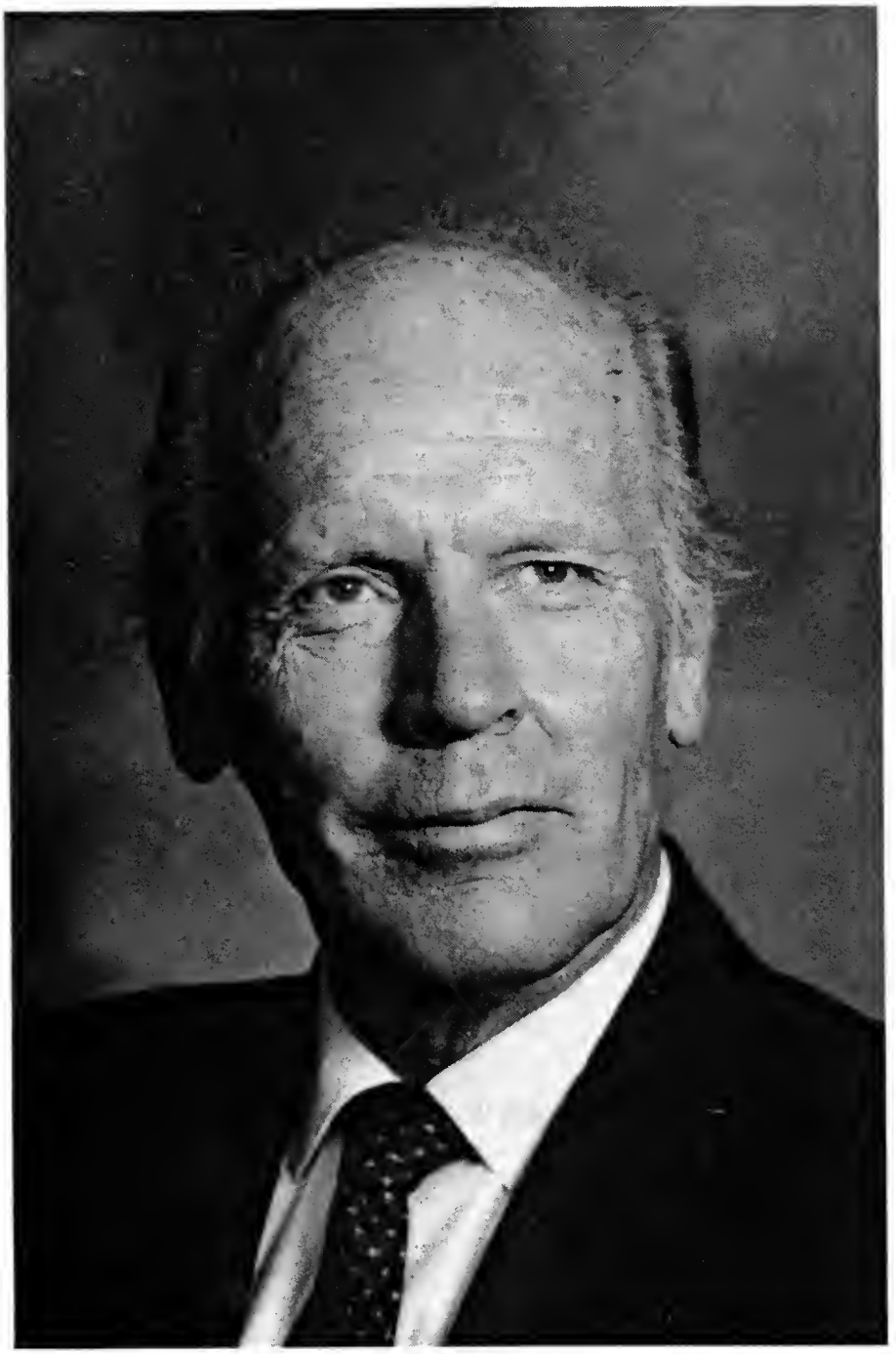

W. L. REIMERS, M.D.

1985

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PREFACE

Background of the Oral History Project

The Kaiser Permanente Medical Care Program recently observed its fortieth anniversary. Today, it is the largest, one of the oldest, and certainly the most influential group practice prepayment health plan in the nation. But in 1938, when Henry J. and Edgar F. Kaiser first collaborated with Dr. Sidney Garfield to provide medical care for the construction workers on the Grand Coulee Dam project in eastern Washington, they could scarcely have envisioned that it would attain the size and have the impact on medical care in the United States that it has today.

In an effort to document and preserve the story of Kaiser Permanente's evolution through the recollections of some of its surviving pioneers, men and women who remember vividly the plan's origins and formative years, the Board of Directors of Kaiser Foundation Hospitals sponsored this oral history project.

In combination with already available records, the interviews serve to enrich Kaiser Permanente's history for its physicians, employees, and members, and to offer a major resource for research into the history of health care financing and delivery, and some of the forces behind the rapid and sweeping changes now underway in the health care field.

A Synopsis of Kaiser Permanente History

There have been several milestones in the history of Kaiser Permanente. One could begin in 1933, when young Dr. Sidney Garfield entered fee-for-service practice in the southern California desert and prepared to care for workers building the Metropolitan Water District aqueduct from the Colorado River to Los Angeles. Circumstances soon caused him to develop a prepaid approach to providing quality care in a small, well-designed hospital near the construction site.

The Kaisers learned of Dr. Garfield's experience in health care financing and delivery through A. B. Ordway, Henry Kaiser's first employee. When they undertook the Grand Coulee project, the Kaisers persuaded Dr. Garfield to come in 1938 to eastern Washington State, where they were managing a consortium constructing the Grand Coulee Dam. Dr. Garfield and a handful of young doctors, whom he persuaded to join him, established a prepaid health plan at the damsite, one which later included the wives and children of workers as well as the workers themselves.

During World War II, Dr. Garfield and his associates--some of whom had followed him from the Coulee Dam project--continued the health plan, again

at the request of the Kaisers, who were now building Liberty Ships in Richmond, California, and on an island in the Columbia River between Vancouver, Washington and Portland, Oregon. The Kaisers would also produce steel in Fontana, California. Eventually, in hospitals and field stations in the Richmond/Oakland communities, in the Portland, Oregon/Vancouver, Washington areas, and in Fontana, the prepaid health care program served some 200,000 shipyard and steel plant employees and their dependents.

By the time the shipyards shut down in 1945, the medical program had enough successful experience behind it to motivate Dr. Garfield, the Kaisers, and a small group of physicians to carry the health plan beyond the employees of the Kaiser companies and offer it to the community as a whole. The doctors had concluded that this form of prepaid, integrated health care was the ideal way to practice medicine. Experience had already proven in the organization's own medical offices and hospitals the health plan's value in offering quality health care at a reasonable cost. Many former shipyard employees and their families also wanted to continue receiving the same type of health care they had known during the war.

Also important were the zeal and commitment of Henry J. Kaiser and his industry associates who agreed with the doctors about the program's values and, despite the antagonism of fee-for-service medicine, were eager for the success of the venture. Indeed, they hoped it might ultimately be expanded thoughout the nation. In September, 1945, the Henry J. Kaiser Company established the Permanente Health Plan, a nonprofit trust, and the medical care program was on its way.

Between 1945 and the mid-1950s, even as membership expanded in California, Oregon, and Washington, serious tensions developed between the doctors and the Kaiser-industry dominated management of the hospitals and health plan. These tensions threatened to tear the Program apart. Reduced to the simplest form, the basic question was, who would control the health plan--management or the doctors? Each had a crucial role in the organization. The symbiotic relationship had to be understood and mutually accepted.

From roughly 1955 to 1958, a small group of men representing management and the doctors, after many committee meetings and much heated debate, agreed upon a medical program reorganization, including a management-medical group contract, probably then unique in the history of medicine. Accord was reached because the participants, despite strong disagreements, were dedicated to the concept of prepaid group medical practice on a self-sustained, nonprofit basis.

After several more years of testing on both sides, a strong partnership emerged among the health plan, hospitals, and physician organizations. Resting on mutual trust and a sound fiscal formula, the Program has attained a strong national identity.

The Oral History Project

In August 1983, the office of Donald Duffy, Vice President, Public and Community Relations for Kaiser Foundation Health Plan and Hospitals, contacted Willa Baum, director of the Regional Oral History Office, about a possible oral history project with twenty to twenty-four pioneers of the Program. A year later the project was underway, funded by Kaiser Foundation Hospitals' Board of Directors.

A project advisory committee, comprised of seven persons with an interest in and knowledge of the organization's history, selected the interviewees and assisted the oral history project as needed. Donald Duffy assumed overall direction and Darlene Basmajian, his assistant, served as liaison with the Regional Oral History Office. Committee members are John Capener, Dr. Cecil Cutting, Donald Duffy, Robert J. Erickson, Scott Fleming, Dr. Paul Lairson, and Walter Palmer.

By year's end, ten pioneers had been selected and had agreed to participate in the project. They are Drs. Cecil Cutting, Sidney Garfield, Raymond Kay, Clifford Keene, Ernest Saward, and John Smillie, and Messrs. Frank Jones, George Link, Eugene Trefethen, Jr., and Avram Yedidia.

By mid-1985 an additional ten had agreed to participate. They are: Drs. Morris Collen, Wallace Cook, Alice Friedman, Benjamin Lewis, Sam Packer, Bill Reimers, Harry Shragg, and David Adelson, Lambreth (Handy) Hancock, and Berniece Oswald.

Plans to interview Dr. Garfield and Dr. Wallace Neighbor, who had been at Grand Coulee with Dr. Garfield, were sadly disrupted by their deaths a week apart in late 1984. Fortunately, both men had been previously interviewed. Their tapes and transcripts are on file in the Central Office of the medical care program. Similarly the project lost Karl Steil due to his lengthy illness and death in 1986.

The advisory committee suggested 1970 as the approximate cutoff date for research and documentation, since by that time the pioneering aspects of the organization had been completed. The Program was then expanding into other regions, and was encountering a new set of challenges such as Medicare and competition from other health maintenance organizations.

Research

Kaiser Permanente staff and the interviewees themselves provided excellent biographical sources on each interviewee as well as published and unpublished material on the history of the Program. The collected papers of Henry J. Kaiser on deposit in The Bancroft Library were also consulted. The oral history project staff collected other Kaiser Permanente publications, and started a file of newspaper articles on current health care topics. Most of this material will be deposited in The Bancroft Library with the oral history volumes. A bibliography is located at the end of the volume.

To gain additional background material for the interviews, the staff talked to five Kaiser Permanente physicians in northern California, two of whom had left the program years ago: Drs. Martin Abel, Richard Geist*, Ephraim Kahn*, James Smith*, and William Bleiberg*. James De Long* in Portland, and William Green*, William Allen*, and Dr. Toby Cole* in Denver talked about the history of their regions. In addition, Peter Morstadt*, formerly executive director of the Denver Medical Society discussed the attitude of the Medical Society toward Kaiser Permanente's years in Denver.

The staff also sought advice from the academic community. James Leiby, a professor in the Department of Social Welfare at UC Berkeley and an advocate of the oral history process, suggested lines of questioning related to his special interest in the administration of and relationships within public and private social agencies. Dr. Philip R. Lee, professor of social medicine and director of the Institute for Health Policy Studies at the University of California Medical School, proposed questions concerning the impact of health maintenance organizations on medical practice in the United States.

Organization of the Project

The Kaiser Permanente Oral History Project staff, comprised of Malca Chall, Sally Hughes, and Ora Huth, met frequently throughout 1985 to assign the interviews, plan the procedures and the time frame for research, interviewing, and editing, and to set up a master index. Interviews with the first nine pioneers took place between February and June, 1985, and with the second group between February and December, 1986. The transcripts of the tapes were edited, reviewed by the interviewees, typed, proofread, indexed, copied, and bound. The entire series will be completed during 1987.

Summary

This oral history project traces, from various individual perspectives, the evolution of the Kaiser Permanente Medical Care Program from 1938 to 1970. Each interview begins with a discussion of the individual's family background and education--those tangible and intangible forces that shaped his or her life. The conversation then shifts to the interviewee's participation in and observation of significant events in the development of the health plan. Thus, the reader is treated not only to facts on the history of the Program, but to opinions about the personal qualities of the men and women--doctors, other health care professionals, lawyers, accountants, and

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*Tapes of these interviews have been deposited in the Microforms Division of The Bancroft Library.

businessmen--who, often against great odds, dedicated themselves to the development of a health care system which, without their commitment and skills, might not have resulted in the individual and organizational achievements that the Kaiser Permanente Medical Care Program represents today.

The Regional Oral History Office was established to tape record autobiographical interviews with persons who have contributed significantly to the development of the West. The office is headed by Willa K. Baum and is under the administrative supervision of James D. Hart, the director of The Bancroft Library.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

23 January 1987
Regional Oral History Office
Berkeley, California

INTERVIEW HISTORY

In 1968, Dr. Wilbur L. (Bill) Reimers heard that the Kaiser Foundation Health Plan was considering expansion to the Denver area. Although he had had a successful solo fee-for-service practice in general surgery in Denver for nearly sixteen years, prepaid group practice intrigued him, particularly in terms of medical economics, a subject he had been studying for several years.

Inquiries among his peers about the Kaiser Permanente organization assured him that it was legitimate and offered a good health plan, even though few indicated interest in leaving solo in favor of group practice. Satisfied, Dr. Reimers went to Los Angeles to talk to Dr. Raymond Kay, long-time director of the Southern California Permanente Medical Group, who, along with the southern California health plan management team, was to sponsor the new Colorado region. After a day spent talking to Dr. Kay, Reimers returned to Denver and quietly began recruiting the first physicians for the medical group. The Colorado Permanente Medical Group, consisting of three doctors, was organized in 1969 with Bill Reimers as chief of surgery. A few months later he became acting director, and in 1970 was elected executive medical director, a post he held until 1984. Until 1973 he combined surgery and administration, but after attending Harvard's Advanced Management Program he gave up his surgical practice to devote full time to managing the medical group. It is upon this aspect of his career, as medical director, that Dr. Reimers concentrates in this interesting and candid interview.

Like all medical directors in the Kaiser program Dr. Reimers had to balance the needs, interests, and desires of the physicians with those of the health plan management. But Reimers faced another challenge--to operate a health plan without its own Kaiser Permanente hospitals. By utilizing only community hospitals and demonstrating conclusively that this was possible, he broke away from what had long been considered an unbreakable component of the Kaiser Permanente "genetic code," namely, the integration of inpatient and outpatient facilities. To achieve this basic change and to have Permanente physicians accepted as equals in Denver's hospitals, Bill Reimers relied on his own reputation and on his credo that the Denver region, in every aspect of its medical care program, had "to go first class." Permanente physicians in Denver have worked alongside fee-for-service doctors and become chiefs of services at community hospitals.

When he was growing up as one of six siblings on a two thousand-acre ranch in western Nebraska, Bill Reimers became acquainted with the local doctor who occasionally took him on his house calls. At that time Reimers knew only that he did not want to be a rancher and that he wanted to go to college to study science. A regent's scholarship enabled him to enroll in the Universiy of Nebraska where he majored in chemistry. Even though he had no idea how he could finance the venture, he applied for medical school and was accepted. Compelled at first to work to support his studies, he

eventually received military financing of the final years of his medical education.

Following medical school he went into the army as a reserve officer, interning first at Ohio State University Hospital, after which he went abroad as a battalion surgeon. At war's end he returned to Ohio to take up a residency under the chief of surgery Dr. Robert Zollinger. Four years later he moved to Denver to continue a residency in surgery under Dr. Henry Swan, chief of surgery at the University of Colorado School of Medicine, and to try his hand at medicine in academia as an instructor in surgery. Not satisfied with teaching, he went into private practice where he remained until 1969 when he joined Kaiser Permanente.

The first of two interview sessions with Dr. Reimers took place on April 7 between 10:00 a.m. and 2:00 p.m. in my Westin Hotel room in downtown Denver. A general outline of the topics for discussion had been sent ahead, based on information gained from transcripts of speeches he had given through the years detailing aspects of the region's history. One of these, "Physician Orientation," along with some other material, has been placed in the appendix. Remaining material will be deposited in The Bancroft Library.

To insure full documentation of the Colorado program, Dr. Reimers thoughtfully arranged interviews for me the next morning with Peter Morstadt, executive secretary of the Denver Medical Society for twenty-five years, and William Green, current health plan manager, who had been, in one capacity or another, with the Colorado region almost since its beginning. At noon over a box lunch in the conference room of Kaiser Permanente headquarters in the Franklin building, he arranged and participated in a roundtable discussion with Dr. Toby Cole (present medical director), William Green, and William Allen (manager, Information Services Department). A hoped-for interview with Dr. David Lawrence, current regional manager, could not be arranged because of our conflicting schedules. The tapes of these highly informative discussions are on deposit in the Microforms Division of The Bancroft Library. Following lunch on April 8, Dr. Reimers and I held a second interview session of less than an hour's duration.

Dr. Reimers, who speaks and writes with clarity, carefully reviewed his transcript, revising a few passages he thought were not clear. Anxious to present a full picture of the Colorado region's history, he let stand his candid evaluations, indicating that it bothered him to do so. This oral history and that of Sam Packer, medical director of the Ohio region, offer enlightening perspectives on the development of the first regions in the Kaiser Permanente Medical Care Program east of the Rockies.

Malca Chall
Interviewer-Editor

18 February 1987
Regional Oral History Office
486 The Bancroft Library
University of California at Berkeley

BIOGRAPHICAL INFORMATION

(Please print or write clearly)

Your full name WILBUR (BILL) LOUIS REIMERS

Date of birth FEBRUARY 26, 1919 Place of birth BIG SPRINGS, NEBRASKA, USA

Father's full name EMIL THEIS REIMERS

Birthplace WILSTER, SCHLESWIG-HOLSTEIN, GERMANY

Occupation FARMER / RANCHER

Mother's full name ELLA REWERTS REIMERS

Birthplace DONIPHAN, NEBRASKA, USA

Occupation HOUSE WIFE / MOTHER

Where did you grow up ? WESTERN NEBRASKA, NEAR BIG SPRINGS

Present community DENVER, COLORADO

Education 1) HIGH SCHOOL, BIG SPRINGS, NE 2) COLLEGE: UNIVERSITY OF NEBRASKA, 1936-44, M.D. DEGREE 3) SURGICAL RESIDENCY: OHIO STATE UNIV. & UNIV. OF COLORADO, 6 YEARS 4) ADVANCED MANAGEMENT HARVARD UNIV, 1973-74

Occupation(s) 1952 - 1973 : SURGEON (GENERAL & THORACIC)
1969-1984: EXECUTIVE MEDICAL DIRECTOR, KAISER PERMANENTE, COLORADO REGION

Special interests or activities

1. CIVIL WAR LITERATURE & HISTORY
2. SPORTS
3. ANTIQUE FURNITURE RESTORATION

I BEGINNING OF THE CAREER IN MEDICINE

[Interview 1: April 7, 1986]##

Family Background and Early Education

Chall: I wanted to get some of your personal background, just so that we know something about the route by which you arrived here. First of all, I want to know where you were born and when, and then we'll go into your family background.

Reimers: I was born in the ranch country of western Nebraska, near the town of Big Springs. It's in the western part of the state. Born of a farm and ranch family, a large family, six children. I went to the state college after high school.

Chall: Could you give me the date of your birth?

Reimers: February 26, 1919.

Chall: Okay. And you were one of six children on a ranch, a wheat ranch?

Reimers: No, a cattle ranch, cattle and farming ranch. We did raise corn, too, and things of that kind, and some wheat, yes. But the cattle was a big part of our operation.

Chall: So your father was a rancher and farmer.

Reimers: That's right.

Chall: Had he or his family lived a long time in the west?

##This symbol indicates that a tape or a segment of a tape has begun or ended. For a guide to the tapes see page 64.

Reimers: No. He was an immigrant as a young man. He was nineteen years old when he came from Germany. He subsequently married an American-born girl, and they moved to western Nebraska, so this was new country for them.

Chall: Had your father grown up on farms in Germany?

Reimers: Yes, he came from an agricultural background, a small farm. His people were heavily involved in the military as well. They had military assignments even though most of the family lived on the farm.

Chall: Why did he come to this country?

Reimers: Because he had relatives here. He was entranced by the possibilities. He wanted to escape further military duty, even though there was no conflict on at that time. He really wanted to get out of the military life.

Chall: It seems to have been a common reason for leaving Germany or Europe at various times. How were the six of you divided among the girls and the boys?

Reimers: Two girls and four boys.

Chall: Were there special expectations for you all in terms of your American education and your prospects for careers?

Reimers: Not specifically. There was an underlying expectation that we should do well in school. Any school beyond high school was left strictly up to us. As a matter of fact, it took some urging and some conniving to get to go to college. My father, for instance, was disappointed that more of the children didn't stay and hold together what he had accumulated, the ranch and so forth. So going to college was somewhat of a problem. Once decided, though, he accepted it, though we had to make our own way through college.

He didn't remain bitter about it; and my mother was very encouraging always for us to go as far as we could go. So we came from a--I won't say an intellectual background--we came from a background in which intellect and training were much admired.

Chall: Were you going to small one-room schools in your elementary years?

Reimers: Not one-room, but small. As a matter of fact, we had two rooms, one of the very few two-room schools in the county. It was a country school. It had the interesting name of Cottonwood Corner, because it was on the corner of a section in which the pioneer people had planted a lot of cottonwood trees, and they decided that's where the school was going to be. The school had been

Reimers: there for a good number of years before we went there. But from there, then we went to high school in the little town. Cottonwood Corner was just through the elementary years.

College and Medical School

Chall: What prompted you to go into medical school, or at what time did you decide you wanted to?

Reimers: I had struck up a friendship with the son of the local doctor. He was older than I, but I got to know him fairly well and he took me on some of his calls. That made me interested in medicine somewhat. I had already decided I was going to college if I could, and I knew that my main interest would be science of some kind. And then I was lucky enough to have won what was called in those days, a Regent's scholarship. These were scholarships put out by the state university, scattered throughout the state, for various kids. Having gotten that as a shoehorn to get into school for a couple of years' free tuition, it helped my escape from home. I knew I didn't want to be a farmer or a rancher.

I also had had the previous good fortune to have a couple of brothers who had made the break, so it was not an unexpected thing in my family. As far as medicine is concerned, I didn't make up my mind exactly that it should be medicine. I majored in chemistry.

Chall: In high school or in college?

Reimers: In college. [University of Nebraska] Then it was toward the end of that period that I took the chance of applying to medical school just on the possibility that some miracle would permit me to go. I didn't know how I would do it, but I was accepted. An interesting thing is that my older brother at that time--he was four years older than I--was teaching high school in the state, and he had always wanted to be a doctor. He had declared that as a boy. I had never really been that bold about it. And when he heard that I, without any money at all, had applied to medical school and been accepted he looked at his own situation. He had a little money that he had saved--he owned a car and so forth--from teaching high school. So he promptly applied also, and we went to medical school together, the same year. [University of Nebraska College of Medicine] Though he was older than I, we were in the same class, and had a devil of a time, working and doing our school work at the same time. But we managed for a couple of years.

Reimers: Then when things were getting a little tight, why, we were then in the war. The military wanted us both as doctors, and so they financed the remainder of the four-year period, which was shortened because of the war, and it only took another year and a half to graduate. But that was done at government expense. So we had easy sliding financially from then on, you know, because we didn't have to sweat out every buck; we didn't have to work quite so hard.

Chall: And then you went directly into the military?

Reimers: I went into the army, though I was activated as a reserve officer and spent nine months as an intern at Ohio State. That was demanded in those days before one could get a license. And that too was shortened from one year to nine months because of the war. And after that I went immediately into the military. I was carried as a student officer, as a student second lieutenant during that period, and paid a minimal amount.

Chall: I notice from '43 to '45 you were a battalion surgeon with the medical corps. Were you in this country or abroad?

Reimers: Abroad, in Europe primarily.

Chall: Then at the end of the war you came out of the service and went into your surgical residency at Ohio State University. So you just went back to where you had been as an intern.

Surgical Residency: Ohio State University Hospital, 1945-1950

Reimers: I did indeed, yes. In the meantime because of my experience in the army I had gotten interested in surgery. I had never been interested in surgery before. And it happened also that I had learned of a man by the name of [Robert] Zollinger, who was going to be the new chief of surgery at Ohio State. He was going to form a new department of surgery. Through him, by mail only, I was accepted into this program. So when I left the service in California I went immediately to Ohio.

Chall: Well, what happened to your brother in the meantime?

Reimers: Almost the same thing happened to him, though he had interned at Tulane in New Orleans. He showed a continuing interest all the way along in internal medicine. He wasn't as flippant as I who had a lot of different medical interests until I settled down. He

Reimers: was an internist all the way. When he came out of the service, almost the same time I did, he went into an internal medicine residency in New Orleans. Again, back to his alma mater.

And that was not accidental. That was happening all over the country, because that was the only place that one had ties. Also, the schools had a strong sense of loyalty toward their veterans, so they bent over backwards to make places for us. So we both went back to the teaching hospitals from which we had come.

Education and Careers of Reimers' Siblings

Chall: Just to go back a bit with the rest of your family--that takes care of two of you. Did any of the others go into professions, the other two boys?

Reimers: My oldest brother did. He was the one who sort of broke ground for the rest of us from the family tradition. He went, basically, into psychology and eventually into social administration, which was kind of a new profession at that time. Every university it seemed was setting up a new school of social administration. He became dean of the school at the University of Connecticut at Storrs, about which we were all very proud. He was a full professor and all that. Then, within a year, he drowned in a lake on vacation. And that was the end of his career.

My other brother never went to college. He sort of stayed with the family farm, except that he went into the military and stayed longer than any of the rest of us. He stayed for, oh, five years. Started earlier and got out later. He then came back to the ranch, and basically stayed there the rest of his life.

Chall: How big was this ranch?

Reimers: It wasn't that big. It was, oh, it was a couple of thousand acres. It was mostly farm land. A lot of the cattle we raised on bottom land. It was land in the valley. Because we didn't have a huge expanse of range land, we bought a good many cattle for feeding in the wintertime. We raised a lot of corn and other crops that we fed to the cattle. In that sense it was a ranch: a farm-ranch combination, with cattle feeding as the main enterprise.

Chall: And how about your sisters? Were there any expectations for them, different from that of the boys in the family?

Reimers: No. One sister went to what was then called a normal school, and became an elementary school teacher and still teaches in Nebraska. She lost her husband shortly after the war, raised a family of four children all by herself. And then the last sibling, my second sister, is a mentally defective lady in her seventies now, living in a mission-like home, a Lutheran-denominational love-filled home in rural Nebraska, where she has been since the death of my mother over twenty-five years ago.

Chall: In other words, she lived a good part of her life with the family?

Reimers: Yes, she lived as long as my mother was alive and able. All through the war, and all that time she lived with my mother. Then when my mother died, we passed her around among members of the family--a deplorable situation--and finally settled on the best of all worlds, I think, and that was very much a religion-oriented country home, handling perhaps a hundred guests or so. And she has stayed there, and considers it her true home. We visit her there, and she comes to visit us.

Surgical Residency and Instructor: University of Colorado, 1950-1952

Chall: Now when you finished your surgical residency after four years at Ohio State University, according to your resume here, you came to Colorado in a surgical residency program and as an instructor in surgery. What brought you to Colorado?

Reimers: Two things: one, the urging of Dr. Zollinger, whose name keeps coming back.

Chall: I saw it in your papers, yes.

Reimers: He thought that I should have some interest in academics. I didn't know whether I did or not, but I knew that I had an interest in Colorado. I had been in the East, what I consider the East, and other places, Boston and so forth. The second reason was that I wanted to come West again, and the opportunity to be added to a new department here in Colorado intrigued me. So I came out here and was accepted and stayed as a resident, even though I had already finished my residency in Ohio.

Dr. [Henry] Swan, who was the chief here, was especially skilled and well-known nationally for his cardiovascular work. At that time I thought that might be a field that I would be interested in. I also thought that I might want to, you know, start as a junior professor, and so on. I guess it's enough to say that I found out my own mind after these two years--they were

Reimers: valuable years of training--that I really didn't want to be part of an academic institution as such, though I've retained my connections with the medical school. I really thought I would rather be in the private practice.

So at that point--because I was not married and I was kind of footloose--I took a job as a ship's doctor on trips to South America for several months and got my thinking straight. I came back, looked around a good deal, and finally decided, along with some urgings of friends of mine, to practice right here in Denver. But I had considered every place west of here.

Chall: Did you look into San Francisco and Oakland?

Reimers: Yes, and at everything in between. I even looked at Kaiser.

Chall: Yes, it was beginning to flourish then.

Reimers: It didn't appeal to me all that much at that time. So, even though I was interviewed and was offered a job in San Francisco at their new hospital in San Francisco, in the department of surgery, I declined it. But it stayed in the back of my mind as a concept that later became reignited. And as a philosophy of care it always intrigued me, though originally I wasn't tempted enough to go with that concept.

Fee-for-Service Practice in Surgery, 1953-1970

Chall: Were you still interested in trying your own hand at fee-for-service and independent medicine?

Reimers: Exactly. And independent was the key word. I wanted to prove to myself that I could stand alone. That was important for me.

Chall: So you came back to Denver and opened up your practice in surgery, then; that's a specialty. That means that people have to be referred to you, by and large. People don't just walk into a surgeon's office cold, very often, do they?

Reimers: That's very true. I would say in over 90 percent of the cases, even after one's been in practice for ten years. You may get repeats within a family or that sort of thing, but most of it is new, referred work.

Chall: So you had to make a kind of name and place for yourself here.

Reimers: With other physicians, yes. That's the only way you can get patients.

Chall: And how did you do? You were successful, I gather, from your resume.

Reimers: I did very well. Though I never entered a partnership, I always had an association with another surgeon to give me time off. Usually just one other one. I went through three different men during that period of time, mostly because they decided to change careers and left me. One of them left town, another went totally into cardiovascular work. I finally got to the point that I was having to restrict my work a good deal in order to have a decent personal life. It can be, in surgery, particularly, because of the twenty-four hour day aspect of it, difficult to do justice to one's family. It seems you either have too much, or too little, to do. I eliminated doing surgery in several of the hospitals to lighten the load. I should not leave the impression, however, that all of this was the reason for my leaving private surgical practice. I enjoyed my practice.

II THE KAISER PERMANENTE MEDICAL CARE PROGRAM COMES TO DENVER, 1968

The Initial Behind-the-Scenes Stages

Chall: Now as I understand it, something like around 1968 or so, 1967-1968, there was some interest on the part of some of the labor people in the area, connected with the United Mine Workers and even the college [University of Colorado] for some kind of pre-paid medical plan here. I've seen the names, Dr. William Dorsey and Ada Kreuger. At some point, when I guess Dr. Dorsey went out to see Dr. [Clifford] Keene about the possibility of some kind of medical program--Kaiser coming out here--were you in any way back of that, or were you aware of it?

Reimers: I was not back of it, and I was scarcely aware of it. I might say, and this is tricky to say, but it's important to say, that Dr. Dorsey and the United Mine Workers were an anathema to most of organized medicine in the city, and to me personally. It was later, when the decision was made that Dr. Dorsey would not be part of it, that I developed an increased interest in it.

Chall: Was Dr. Dorsey an anathema to the practitioners in this area, organized medicine, because he was with the United Mine Workers and their own medical program, or was there something about him personally?

Reimers: I think the attitude among doctors in Denver toward Dorsey was more because of the way he did his job than toward him personally. Actually, Bill was a friendly and gracious person whose job was to organize medical care for United Mine Workers as cheaply as possible. He did this by working with physicians who would reduce their fees significantly to get the work he controlled. Whether true or not, he got the reputation of being more interested in "bargain basement" medicine than quality of the care he was delivering. Unfortunately this stigma also fell upon those physicians who cared for his workers. I operated upon a few UMW patients early in my practice but quickly quit to maintain my

Reimers: status among the majority of doctors, who would not bargain with Dr. Dorsey over fees. So I think the general feeling about him was that chiselling down fees was demeaning the practice of medicine, and probably reduced the quality of care. Certainly that was my view at that time.

Chall: I see. So generally the doctors that he was using--when you say they weren't well thought of--do you mean they weren't well thought of because you thought they were poor doctors, or because they worked in this kind of plan?

Reimers: Both. I think maybe more the latter than the former. Poor doctors. I would think doctors with questionable ethics is what I'm trying to say.

Chall: Yes. So what we're really saying is that this was a forerunner of the way organized medicine and doctors in general looked at the Kaiser program, wherever it went, wherever it started at the beginning. This was their attitude toward it. I just wanted to make sure that I got that clear.

Reimers: That's right. I think, it was certainly not anything about Bill Dorsey personally, and it was not particularly poor doctors in that sense. They were not as highly principled as we would have hoped they would be.

Chall: Okay.

Reimers: It is interesting that later, with Kaiser, I used some of the same tactics to hold down the cost of referral fees that Dr. Dorsey had done previously--and was thought of, by some physicians, as a second Bill Dorsey. This was minimized, however, by declaring to "go first class" in selecting as referral specialists physicians who were above reproach. One could say, I suppose, that CPMG exploited the spotless reputations of these men and thereby avoided the Dorsey stigma.

As for the early contacts between Dorsey and Kaiser I know very little. The organization that presumably initiated these talks was known as CLEAR. Have you seen a reference to this group in your research?

Chall: Yes, I did. I just saw that today.

Reimers: I don't even know what those letters stand for any more.* But that all went on without me, even to the point of disturbing me a bit, that this was being done by people who were not in organized medicine. As a matter of fact, an anecdote about that is that organized medicine had to ask whether they could come to these meetings. With some reluctance, CLEAR allowed a representative from either DMS or CMS, Denver Medicine Society or Colorado Medical Society, to come to the meetings as observors only.

But they did not take this group of providers and say, "We'd like to bring you into this thinking." The thinking came from the school, an intellectual approach to the problem; came from labor, which was very much pushing for it; and came from people like Bill Dorsey; who could speak from experience as to how he provided care to a large organization far-flung throughout the West, on the basis of reduced fees. The providers were not part of those early meetings of CLEAR, and resented being excluded.

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Reimers: An awareness of a non-traditional approach to the delivery of medical care was beginning to be felt throughout the city.

Chall: So this was a meeting where the Kaiser people had come in?

Reimers: Yes.

Chall: That seminar in, I guess, March that they talk about [sponsored by the University of Colorado Medical School].

Reimers: Right. And how many meetings they had before Kaiser was asked in and so on, I don't know. Also at that time, when Kaiser did come, they did interview doctors. I don't know how they advertised this, but they did let some doctors know that they were willing to interview them to see whether they would be interested in becoming involved in such a plan. I was not one of those. I later saw the notes of interviews of, oh, twenty-five or thirty doctors that had been talked to, that had varying degrees of interest. Most of them were just trying to find out what it was all about, and we later went through those notes to see whether any of those might be reasonable recruits. That was a year or two later. But I was not a part of that early contact by Kaiser, nor did I wish to be at that time.

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*Center for Labor Education and Research.

Bill Reimers Becomes Involves: Quietly Builds a Staff

Chall: So I guess in those early days, Mr. Karl Steil and Dr. Keene came in and looked over the situation and put Dr. Raymond Kay in charge. But you still weren't involved.

Reimers: I wasn't involved.

Chall: How did you get involved? At what point?

Reimers: Well, it was in the spring of '68 that the thing had come to more than just a rumor. I, of course, knew of Kaiser. I had been involved in many socio-economic aspects of medical care in the state medical society for some time. I had been looking at what was then called the "foundation" approach out on the coast, in California. It was a more organized kind of care where doctors had an equal involvement. And I was interested in this concept.

There's a clinic of high respect here in town called the Denver Clinic. It was built, oh, along the lines of the Mayo Clinic; highly-regarded people, many of whom I knew and many of whom I did surgery for in the past. They had their own surgeons sometimes; sometimes they didn't. So that I got to do some of their work. I went to the man who was the head of it, Frank McGlone. That would be an important name to document. He had been approached by Dr. Kay, and I had heard that the Denver Clinic was giving it some consideration.

So I went to Frank, who was a friend of mine, and I said, "Frank, if you people see enough merit in this new approach, I would like to become part of it." Or, "I would like to know more about it. Because if you passed on it, that takes it out of this feathery area now and makes it more legitimate." And Frank said, "We've just decided today at lunch that we don't want any part of it. But it's more because we don't know how to do it along with our private practice." He said, "I think it's a pretty legitimate outfit."

So I got involved by saying, "Can you get me an appointment with somebody to talk to?" And he said, "Yes, I have his name right here. Let me call him." So right there in his office--like April or May of '68--Frank called Ray Kay in Los Angeles. We set up an appointment for a week later. I pledged everybody to secrecy, including my wife, and disappeared for a couple of days. I went out, and I talked with Ray Kay at length.

Chall: You went to Los Angeles to see him?

Reimers: Yes, North Hollywood. Their offices were there; I think they still are. He was enough interested and I was enough interested that I stayed a whole day, and some into the next. We had gone far enough that I was asked, "Can you put a group together?" I said, "I have no idea. Let's talk about what it would mean to the doctors, what kind of money you're talking about, lifestyle, and so forth."

So I came back to Denver quite excited. I couldn't tell anybody, except my wife, what I had been doing. I started very secretly talking to people and gathering around myself a little group. Most of the doctors I approached were cool about the idea. But a couple of extremely high-quality guys, one of whom had been interviewed by Dr. Kay in the months or years before, was Dave Blanchet. He was one of the founding members. Blanchet--B-L-A-N-C-H-E-T, one "T."*

Chall: That's interesting. I see it spelled with two, even in this Kaiser-Permanente annual of '69.**

Reimers: Well, wait a minute now.

Chall: Well, that's all right. I'll check it out before we go any further, because I don't want it to be an error either. But I know he was important to you.

Reimers: He was, and he, in my mind, has always remained--even though he quit us later--he always remained a doctor's doctor. He has never been anything except the most exemplary kind of professional. Because he had worked closely with a particular pediatrician--Dave was an OB man--and I had worked with the same pediatrician, we finally settled on asking Robb [Robert] Howard. There was no question about his integrity and his standing in the community and so forth.

We knew we had to go first-class to get it off the ground, and to some extent the prejudice--I'm sure it was that--against Bill Dorsey stuck in our minds. You couldn't have the image that Bill Dorsey had and make this thing work. Now, you may hear a different story from other people, particularly the non-doctors from the coast who talked with Bill Dorsey. But that's the way it was here in Denver. I had distanced myself deliberately from Bill Dorsey as much as I could. I went to see him occasionally in his

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*Blanchet is correct. [B.R.]

**For an early history of the Colorado region, see Kaiser Foundation Medical Care Program, 1969, 18-21.

Reimers: home, or his office. But usually he asked me to come over to be brought up to date as to what we were planning. I had nothing against him personally, but I told Ray Kay, "Don't expect me to go any further with this if Bill Dorsey is in the picture." So he said, "Bill Dorsey isn't in the picture. He's got his own job. He doesn't want to take over this too, so you should have no problem." So I got over that objection. And it was a big problem, in those very early days.

Chall: So you now had two doctors with you, Robb Howard and Dave Blanchet, and you were a third. With this trio you decided to develop your medical group, the whole program, right here. That took a bit of work.

Reimers: That's right. I knew we needed more physicians, but I felt encouraged to have gotten these two high-quality people. I felt that we would find other people. We decided we should retain high standards for recruiting. We never did find maybe the most important man that we should have had on opening day--a chief of internal medicine. We couldn't find one of the caliber that we all wanted. So it wasn't until a year later that we finally got one. We actually signed him up before he had finished his internist residency--that was Jack Sholz. And he still remains with the group and is a very high-quality individual.

Chall: What about Dr. Howard?

Reimers: He was the first pediatrician I spoke of earlier. He stayed with us and he was retired this last year. He was retired soon after I was retired.

Chall: So he stayed committed all the time, as you did.

Reimers: Yes. And my right-hand, as a matter of fact. Maybe I was his right-hand man, I don't know. But we would lean on each other and agonize with each other a great deal. We became very close friends.

Chall: How did you work with the people who came from the Central Office, then, and from southern California to put all this together? When I read the 1969 annual, which explains your beginning here, it sounded quite exciting, not to say difficult, getting the medical building set up within a few months' time, and getting into practice. So I guess you got relatively well acquainted with some of these people. But mainly was it with the southern Californians and Dr. Kay? What about Felix Day? I think he stayed on awhile.

Reimers: Felix Day--I never really saw Felix Day. He was part of the group that was secretly looking over the city prior to Kaiser's decision to come to Denver. So I think I perhaps met him, but I never knew him, never worked with him. The same is true of Warren Ogden; I never knew the man.

Chall: Those are the people who preceded you.

Reimers: Yes.

Chall: They came in, studied the city and wrote up the feasibility studies.

Reimers: And they may have gone to some of these CLEAR meetings, but remember, I wasn't on the scene then.

Chall: Well then, you might tell me how you worked with the southern California people who were your general advisors in all of this. Dr. Kay, for example--how did you work with him?

Reimers: You recall from the other write-ups that the Denver area was under the sponsorship of southern California, and it was a joint sponsorship of both the health plan and the medical group. So those positions were personified by Kay [medical group] and [James] Vohs. Vohs was regional manager at that time. So Ray and Jim flew out here about every week or two during that period, one or the other. They were out here a good deal.

The Route to Becoming Medical Director

Reimers: The first problem came because Ray was about to be retired as medical director in southern California, and gave some thought about becoming the medical director for Colorado. He would move here, or would commute from here over a two or three-year period until a medical director was found. I had no interest in being a medical director. I wanted to form a department of surgery. I still had enough of the old academic urgings in me that I wanted to form a department of surgery around my own standards of surgical practice. I wanted it to be the best one in the state. I had no interest in administrative medicine.

So we were all looking around for someone to be the medical director. Kay could not, because he did not have a license in this state. For him to have to pass the required examinations in his late sixties was an impossibility, he felt, and so he promptly gave up the idea of becoming the medical director.

Then we talked about, well, how can this work? Who can we get? And I think they explored some prospects back on the coast. I don't know just what it was all about, but before long, Jim Vohs privately came to town and asked to have dinner with me one evening. He asked me if I would become the medical director pro tem, until we could get a medical group together that would select its own leader. His point was that in order to deal with the

Reimers: hospitals, we had to have a front man who could speak for us here. "You would suit the purpose perfectly, because you're well known here. If we ship somebody, that's going to be a problem. So how about doing it for the time being?"

Well, you know, I had some misgivings about a lot of it. One was, that was not the way that Ray Kay wanted it. He wanted to stay here and be the medical director and work through me, without me actually being in the job. And I didn't think that would work. I indicated that either I take the whole job or I didn't want any of it. Even if I did take it over, as soon as we could find somebody else to do it, I would give it up. So that's what happened back in about 1970, I guess. This was after we had started, because I was not the medical director at the time we started.

Chall: No. Who was? Or was there one?

Reimers: There wasn't anyone.

Chall: I didn't see any name on the chart.

Reimers: And then I was the acting medical director who was never really in charge. I had no real title, not until a year or so later, when we had to put a partnership together and the medical group named me the medical director. That was a slow personal process of coming to, well, of becoming a medical director.

Chall: And who was acting in 1969, when things got started? Nobody had the title, or somebody was doing the work without the title?

Reimers: I was doing the work without the title. And Ray was here much of the time, so we would refer problems to him. Of course, he hired the very first three physicians, but even beyond that, after we got a nucleus, he still hired several doctors himself. And determined how they should be paid and all that. So he was still here, and making the important decisions.

It was late that year, I would think, after we got started in July, that the "rubber-met-the-road" and we had to make a decision. I don't know exactly when that was made, but I would guess late that year, that I agreed to become the acting medical director. I know, that in the process, Ray Kay's feelings were hurt.

Chall: They were? Even though he knew that he couldn't do it legally? He thought he could act and you would be his puppet?

Reimers: Sort of like that. We sat in a car several times at the airport--we got out there a little early--and we would always eventually get around to this question late, you see. We both wanted to avoid it. Ray and I became very good friends later, because he has his son-in-law here.

Chall: Yes, Mr. [William] Green. [Health Plan Manager]

Reimers: But there has always been a little estrangement over the way I handled that. I wish that it could have been better. I really didn't want to be the medical director, but someone with a Colorado license had to represent CPMG. I was jealous about the position of chief of surgery; I wanted to form a department of surgery. And I knew people at the school and at various places that I had my eyes on who would help me form a department.

Chall: You did practice surgery with the group though, for a number of years, but you couldn't be head of the department, is that it?

Reimers: Yes, that's exactly right. As soon as I agreed to become the acting director and we got another surgeon full time, he became the chief of surgery.

Chall: How then, did you finally decide to become acting medical director, and in what way was Dr. Kay hurt by your decision?

Reimers: I had agreed to serve as the medical director knowing that: one, I had been the spokesman for the medical group for several months anyway, and, two, I could always be replaced later, after getting the program started.

As for Dr. Kay's feelings, I can understand why he would feel hurt. After all, he was primarily responsible for my approval by the Kaiser-Permanente committee. I'm sure it appeared to him that, once I got my foot in the door, I moved to squeeze him out of the picture.

Chall: Did you stop your surgery when you took on the medical directorship, or were you able to continue practicing medicine?

Reimers: I continued practicing surgery for about five years. However, it was greatly diminished from my fee-for-service load. When we started we agreed that we would keep what private patients we could to help pay our salaries. Because we had only 700 members. Robb Howard was able to keep his practice pretty well, because he was a pediatrician. Dave Blanchet kept a surprising number of his patients. He couldn't get rid of them. They wouldn't drop him. And you asked the key question earlier. I was a referral doctor; neither of them were. So my practice dropped off almost over-

Reimers: night. I still did some surgery from the outside, but mostly it was from within the group. I worked like this for a few years. Eventually I made the decision to quit completely.

Chall: Is that so?

Reimers: And that was a difficult time for me. I went to the Harvard Advanced Management Program in '73--actually for two summers. That's when I made the final decision. It wasn't five years, it was more like four years. I concluded at that time: If I'm going away to Harvard to learn more about the management field, I can't cling to the claim that I'm still a surgeon. So when I left in the summer of '73, I quit surgery totally.

Chall: How was that class, by the way, in medical administration? Did it help?

Reimers: It was not medical. That's what was initially troublesome about it, but it turned out to be fun. It was management in general. I was the only practicing doctor in the class of 150 people. These were presidents and executive officers of major companies from all over the world. It's one of the most prestigious things I've ever been involved in. And I was swamped at first. I didn't even know the vocabulary, especially in finance. But it was a great experience for me. Jim Vohs talked to me, asked me if I would be interested in it. When I thought about it, I thought it was an opportunity I would not like to give up. After my favorable experience many other Permanente physicians from other regions went through the program. But I was the first--and proud of it.

Chall: How long were you there?

Reimers: I was there for two summers, but they were just short summer periods, seven weeks each. Rather than going fourteen or fifteen weeks all at one shot, which they offer, they had this peculiar once-a-year program that was split up. So I took that one and was gone from home for almost two months for each of those two summers. Robb took over for me in Denver and I stepped out of clinical practice.

Chall: And became a full-time medical director. Did the Harvard class help in administration?

Reimers: Very much. And mostly because it gave me a sense of belonging to a group of executives, acting like an executive, and it gave me the confidence to be able to talk with executives. One other thing was my training in medicine. I had always had--I don't know whether you call it a feeling of insecurity, or what. But I always had the feeling that I wanted the best possible training

Reimers: that I could get before I would accept a new responsibility. You know, some people are willing to try anything with minimal training and can be very aggressive about it.

I don't know that I am the opposite, but to be given this opportunity in management was parallel to the way I had regarded my professional training prior to that. I had overtrained, in a sense. I had gone through six years of residency when only four were required. And so to overdo this, in this way, in a sense gave me a feeling of having made the commitment for the right reasons. So it was a favor that Jim Vohs did for me that was greatly appreciated and very beneficial.

Chall: Good. Well, business people often say that the doctors are not managers, they don't know how to be managers, they weren't trained to be managers and that that's one of the problems with some HMOs today.

As for Ray Kay, was he helpful in your original training in how to set up a medical group and how to go about dealing with it? He certainly was experienced.

Reimers: Very much so; very pragmatic. He was an extremely flexible man, so that if he couldn't make it one way, he would figure another way to do it. He was just the opposite from being rigid or stubborn. So working with him was extremely helpful.

Chall: Well, you had a good start then.

Reimers: Yes, I did. Good people. And we haven't mentioned [John] Boardman yet.

Chall: No, let's start. Now in terms of those people who were in charge of the other parts of the triangle in the Kaiser program at the beginning, one was John Boardman. He was brought in from southern California, wasn't he, to be the regional manager in 1969?

Reimers: Yes.

Chall: He only stayed a year, as I understand it. How was he as a regional manager initially?

Reimers: Excellent. He was on site, whereas Kay never was, and Jim never was. So I related to Boardman very closely and developed an extremely close, almost a brother-like relationship, with him. To some extent this was because I had alienated myself from parts of the medical community and other friends. So maybe I turned to him for help in a field in which I was not comfortable. But I think everyone felt that John Boardman was an extremely fine individual.

Reimers: It happened that his wife and my wife became very close. We even took a vacation together to Hawaii once. And we followed each other's careers very closely, even after John left here.

John did not leave here because of any inadequacy. He left here because he was greatly needed in southern California. Jim brought him back, and that's of course when [Carl] Berner was assigned here. But John Boardman was very helpful and maybe pivotal to some of the relationships that we had to set up with other providers in the city, hospitals primarily; but others, too. We worked very closely together every day. That's one of the reasons why we got to know each other so well; our problems were joint problems.

III THE CAREER AS EXECUTIVE MEDICAL DIRECTOR, 1970-1984

Reimers: When we first started, of course, I was a leading figure because I had put the group together, but I worked with Ray Kay, and he sort of called the signals and I carried them out. Later on, at the end of 1969 or the beginning of 1970, Ray disappeared from the scene. Then I worked primarily with Jim Vohs directly, or with Mr. Boardman, and then took over the job of medical director on my own.

Another thing was that our problems were so local and so dependent on local providers that an outside medical director, even Ray Kay with his tremendous experience, could not give me much help except hints as to what I might try. Because everything depended upon the local people, the local situation, what kind of relationships we had, what kind of financial arrangements were possible. And every city is different.

The idea of shipping in a medical director is a kind of a foreign idea anyway, because really you need someone who has historical roots, professional roots in the community, who is himself respected, before you can begin to work with respectable people. So it was important, and I always contended it was. Even today, when we start new regions, if at all possible, I think we should start with a man who is indigenous to that area. He will save himself a lot of headaches, because, first of all, he's not an alien. The first thing that most people dislike about new people is they're intruders and outsiders.

Chall: Particularly with a foreign idea like this one, or like this one was.

Reimers: Right. So it was almost better for me to be thought of as a traitor, than as a newcomer. At least they knew me. I had some crazy ideas, but they knew me. They knew what they could count on from me--good or bad!

The Reaction of Organized Medicine

Chall: They knew they could count on you as a good doctor in your field. But I think you told me earlier that you became very close to Carl Berner as you had to Boardman because you were beginning to be alienated from your old friends in the medical community. That must come as a sort of sad shock. What happened?

Reimers: Well, it's because, maybe from the way I spent my days compared to the way I had previously spent my days. I no longer had any surgery to do, I no longer was in the hospital as much as I had been, or in the operating room. I was spending more of my day with administrative things, working closely with John and Carl. So it to some extent was to be expected.

On the other hand, there was no question I was being alienated; no question my wife was being alienated from the medical community. She finally even dropped from the auxiliary, the medical auxiliary to which the wives usually belong, because she had been ill-treated there and snubbed. It was just more pleasant for her not to go.

So this happened to us. It happened to her in some ways more than to me, because I was still on the scene. People wouldn't necessarily call me for lunch, but they would recognize me. I remained active in all organized functions that I could, so I could remain visible, and talked with whomever I wanted to talk.

But it is true that I got to working closely with those two men [John and Carl] particularly in those early days, and with Jim too, so that we became surprisingly close. You know, our futures were together and we had problems that we had to work out. In general during those years we were growing, which is always good. Even if you can't keep up quite, at least you've got enough money to buy the services, or in other ways provide the services. So we were growing, and that was about the only good thing about this program during several of those early years. We had some very bad times otherwise. But at least the program was growing, and we were becoming more respectable in the community by doctors, by other people.

Recruiting the Medical Staff

Chall: How did you manage the relationships between the fee-for-service referral doctors that you relied upon so largely in the early days and your attempts to gather up your own staff and develop your own partners? How did it work out between these two groups?

Reimers: Well, in some respect we tried to avoid comparisons between the groups by keeping them separate from each other. Because it didn't do us any good to have our doctors realize that some doctors on the outside were making three times what they were making.

Chall: But they must have been able to understand it, because they would have known what fee-for-service doctors were making, wouldn't they?

Reimers: In general. But they didn't know exactly, because they were brand new doctors, and they had never experienced it themselves. They really wouldn't have known precisely what others made. And doctors generally are very tightlipped and close-mouthed about how much money they make. Nobody brags about it. And you could say, "Well, he's making $150,000 a year. Well, all right, what's his overhead?" Sometimes doctors' overhead reaches 50 percent. Well, you can talk in those big terms. And besides that, how long does it take you to build a practice that's going to net you $150,000 a year? You're just a young doctor, just starting. Are you going to work for ten years and build a practice and go through all the risks that it takes, or do you want a job right now that will pay you more for the first five years of your practice than it will in the private sector? And that is generally true. It was, at least in those days.

So you have a pretty good argument. Do you want it now or do you want it later? Do you want the lifestyle? Do you enjoy the comradery of working with a group of doctors with the same patients, or do you want to work in a solo office? If that's what you want, then you're not in the right place.

We did have problems in convincing doctors they were being paid enough in those years. We made surveys all over the country of what they were paid in various groups. We never attempted to meet the incomes in the private sector. But it was important for us to keep incomes fairly close to other Kaiser regions and to other group practices of the same type.

It was a little disquieting to those who knew how much money we, in fact, would spend out every month, paying for fees-for-service, compared with our own payroll. For many years, we paid more money out every month for fees-for-service than we did our own payroll, which was shocking, even when you're up to sixty or eighty doctors, to think that you're still paying out such huge amounts of money on the outside. Much of that has been relieved now because we're bigger, also the fees on the outside have moderated some in recent years.

Chall: Your doctors who came into the program then were generally out of medical school? Is that where you did your recruiting?

Reimers: Out of residency training, where they're all specialists, yes.

Chall: And where? Here primarily, in Colorado?

Reimers: No, not primarily here. We've always gotten a few from here, but maybe one of the reasons why we didn't get a large number from here was that people coming out of training here would have linkages with fee-for-service doctors before they finished their training. So they tended to join a group here in the city, whereas somebody coming in from Bridgeport, Connecticut or elsewhere, didn't have any contacts here in the city. So he came to us, responding to our ads or whatever, and fit into our program, really easier than he could join the fee-for-service community. So the fact is that we got most of our physicians from outside the city.

Chall: Then did you have to orient them to what it was to be a doctor in the Kaiser program, what the sort of culture, as it were, meant, and the fact that they would always be watched by their peers?

Reimers: Yes.

Chall: They were used to that, of course, in medical school and in their residency work, but they had to fit into it.

Reimers: Had to be reminded of it though. Another group that we got some doctors from, in the earlier days, was the armed forces, especially after the Vietnam War. Our kind of practice was a little bit like that in the service, that is, they worked on a defined population of patients, paid by salary, and so on. So those people fit in fairly well. People coming out of the service or right out of training were fairly aware of what was expected of them. We went through a period of orientation with each doctor--as a matter of fact, starting with his interview--to be sure that he understood the kind of practice he was getting into.

We think some of the early mistakes we made were that we didn't make it clear enough to recruits as to what a group practice pre-paid was all about. So we have spent a lot of time, especially in recent years, to be sure a doctor doesn't join the program without some understanding of what it's like. He may not know what he's joining, because he may not have ever experienced it. It may not be what he expected, but he should have been told. You know, we all make mistakes; we make them, they make them. So after a year or two if a doctor decides he wants to go elsewhere, that's fine. But it shouldn't be from lack of information.

Chall: You had to learn then, gradually, how to orient your doctors. Did you learn that just from experience, or did you learn that by talking to people in other Kaiser programs about how they did their recruiting?

Reimers: Mostly through our own experience, because our own situation was so different. We had a very skilled man here who not only worked but was happy working in this recruitment area. That was Robb Howard.

Chall: Oh, I see.

Reimers: Robb Howard was a committed recruiter, one of the finest recruiters I've ever known. He was a straightforward, honest man. So the new doctor felt like he had been honestly dealt with. He hadn't been sold a bill of good, and he hadn't been hyped into the job. Robb was careful to tell him what he could expect. And it was interesting how many times these young doctors would come back a month or two later, and chat with Robb, because they grew to love him, actually, and to rely on his judgment. So Robb was an unseen strong supporter of the program and particularly of me. Without him I would have been far less successful.*

Functioning Solely with Community Hospitals

Chall: You had to work with local hospitals--you didn't have your own hospital at first. Do you have a hospital yet?

Reimers: No.

Chall: You don't. Now that was defying, in a sense, what Dr. Garfield and the Kaiser pioneers considered the genetic code. I'm not sure that that's considered any longer a part of the genetic code, but certainly it was then. How did you work this out with the hospitals?

Reimers: Even though I was not personally present at the very early Kaiser-Permanente Committee meetings it is my understanding that from the very start Colorado was assumed to be an experimental project.

First, could it be shown that the Kaiser-Permanente formula of success could be made to work east of the Rockies? And starting from "scratch" without any pre-existing program, staff or factilities? Was there something unique about the west coast states that could not be replicated elsewhere?

For additional discussion on recruitment see pages 32-33 and 54-55.

Reimers: Second, could the program succeed without its own program-owned hospital? If so, how long would this be so? I think, at first, everyone assumed a hospital was essential to long-term success.

Of course, as the years passed we in Colorado formed a totally new medical group, worked in other peoples' hospitals, grew in membership, prospered financially and produced affirmative answers to those questions originally posed by the K-P Committee. The spread of Kaiser Permanente to many new regions and the widespread use of community hospitals is proof, I think, of the validity of the new approaches started in Colorado in 1969. As for Dr. Garfield's genetic code, there's nothing magic about that. It's been broken many times in many ways without any resulting calamity. At any rate, the Colorado region has managed nicely through the years without owning its own hospital.

Chall: And you proved it didn't have to have one.

Reimers: Jim and I have talked often about it, as well as Walt Palmer. At Kaiser-Permanente meetings he would ask the question: "Bill, do you think it will ever be necessary to build a hospital?" Everyone else around the room would chuckle and snicker and I would say what I felt: "No, we may not ever need a hospital." The guffaws would drown me out, because a region had never functioned without a hospital before.

Chall: Integrated service is considered essential. Integrated service meant your own hospital and your own clinic, and generally they were very close together, maybe contiguous.

Reimers: I'm sure integration can occur in other ways, and so maybe we should broaden the definition of what integration means.

Chall: How has it worked out?

Reimers: It has worked out well. Here it was worked out on a number of formulae: a cost discount for beds; in later years, a certain guarantee of bed usage, because the hospital needed the income and they needed to project it a whole year in advance. We knew our program well enough to know we needed a certain number of beds. We cut that back a bit to be conservative and say, "Ok, we'll pay you for 200,000 bed days, whether we use them or not." We knew full well we would use them, and they didn't know whether or not they would need them for other patients. This arrangement guaranteed a minimum bed usage--which was important to their budget. Also there was always a little bit of a scare that we would become disillusioned with them and move to another hospital, in which case we would pull the rug out from under them.

Chall: They needed you.

Reimers: They needed us, and we needed them. In later years it was possible--through a difference in personnel changes and attitude changes, mostly at the hospital more than with our own people--it was possible to get volume discounts of considerable importance to us. In the early days we paid standard bed rates, without any favoritism at all. Later on we did begin to get some discounts. One year I remember that it was just a straight 5 percent discount off the top. Well, that didn't seem like much, but it was some. So, through the years a number of mechanisms have been used to pay for those beds.

It was for our own benefit as well as that of the hospital, and for the health plan too, to concentrate our patients as much as we could in one hospital, to obtain the efficiencies we needed. We were not put in the situation of having to bargain for beds all over town. We did our bargaining with one main institution, realizing that we would spill over some into others, or we would use a children's hospital, or some specialty hospital. But in general our bed rates were determined by our arrangements with St. Joseph Hospital.

Chall: Were they considered out of the pale because they took you on?

Reimers: I believe they were. And I mentioned a bit ago an organization called the Midtown Hospital Association, made up of five hospitals in midtown Denver. It's interesting historically, that, though St. Joseph wanted and needed our patients, because they had empty beds, they would not accept us alone. They managed to get the Midtown Hospital Association to approve us, giving us the right to use any hospital in that group: Presbyterian, Mercy, and others. Once they got the approval from the Midtown Hospital Association, St. Joe's then had courage enough to deal with us one-on-one. The other hospitals often grumbled later that St. Joseph had in fact pulled a fast one in doing that, in making them believe that they were going to split up all the work when in fact they grabbed onto as much of our work as they could get for their own best interests. I don't think there's anything false about that; I think it was legitimate self-interest--which has always characterized St. Joseph. But it answers your question in some regard, and that is, that St. Joe's didn't want to face the consequences of this decision totally by themselves.

Chall: Now much of the financial balance of the Kaiser program is based upon determining how much it's going to cost the hospital and the clinic, and arranging for a certain amount of extra money coming in for rebuilding and renovating, and that's partly based on what the doctors are going to earn. So it must have been rather difficult to take that formula then and deal with this outside facility. I suppose I should ask the health plan manager. That was Mr. Kneedler for many, many years, wasn't it?

Reimers: Yes.

Chall: I can ask Mr. Green tomorrow.* But that's again another way of having to deal with the finances and the team approach.

Reimers: Exactly right. Now it's interesting, to the outside world, when we put a budget together, what we say is, "Let's see what we need in every category and put in the requests, and then convert that total need to a prospective premium rate, and see whether that's going to require us to increase the rate for the coming year." Now that's ideally the way it's supposed to work, you see. Regardless of what Bill will tell you, the way it really works is that you see how you stand in the marketplace and say, "We can tolerate a 5 percent increase this next year, and that's all." All right, using that then as the target, you don't reach that by adding everything else together, you reach that point and then work back from that.

In a sense you work it both ways, and because we never did have our hospital, we always had a big hospital expense in terms of pay out. On the other hand, we never had any hospital construction costs. And we didn't have the costs of running a hospital, particularly in building a hospital up from a small unit to a big one. You have to pour in a lot of construction money, and construction money is big money.

Now, what we did in this region--and if you were to visit the region you would see it right away--is that we put a lot of money, not as much as a hospital, but a lot of money into outpatient facilities. So we have beautiful--lavish almost--outpatient facilities that sort of startle people. How is it that these people can build such palatial clinics? Well, part of it was my insistence and others', that we go "first class." We can't go in with tarpaper shacks and try to sell these people, because they're used to going to the doctor's offices, and they're always nice.

So to some extent we had to put in--I'm not answering your question totally, but we had a different requirement for our budget than those regions that own hospitals. And there are some trade-offs both ways.

Chall: What about the physicians? Generally the physician in chief holds that position in both the clinic and the hospital. How did you handle that in somebody else's hospital?

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*A taped interview with William Green is in the Microfilm Division of the Bancroft Library.

Reimers: By becoming very active in their staff activities, as equals with other staff members, not separate from them. A number of our men were to become chiefs of services; chief of OB, chief of surgery, and so forth. We've had that happen many times.

Chall: Even your own partners?

Reimers: Yes. And they were well accepted. Some of our men who were obviously superior people got to be chiefs of service. So we worked it as the private sector worked it. That is, you join the staff and you work within the staff. We were all working for quality care, good medical care. There aren't that many conflicting attitudes, really.

Chall: I see. Well, you had to prove it.

Other Facets of the Medical Program

Chall: Do you have your own pharmacies, as they do in the other centers?

Reimers: Yes. And we did from the start. We started the pharmacies, I think, the day we opened the first clinic. And we do in every new clinic we start, even the very small clinics have a pharmacist.

Chall: How far out of Denver are you now? Or are you out of Denver?

Reimers: No, we're not out of Denver.

Chall: I saw one of your new clinics last night, in the general high-tech area; it's brick.

Reimers: Yes, Arapahoe. We're outside Denver proper, of course, but we're still in the metropolitan area. The region will, I think by the end of the year, start up a clinic in Boulder. That will be the first clinic outside of the metropolitan area.

Chall: How have you gained your membership? Where does that come from?

Reimers: Primarily from employee groups, of course. Until recently it was growth within groups. I understand that within the last year growth within groups has slowed down, and our growth is coming more from new groups. However, our growth in the last couple of years has been disappointing.

Chall: That's because of competition?

Reimers: Yes, I think almost totally.

Chall: Well, that's a problem that all the Kaiser programs are trying to meet, I think.

Reimers: Yes. It's competition in the broadest sense. That is that the fee-for-service doctors are finding ways of doing everything we do.

Chall: Have you provided for your medical staff opportunities for research and education, all those extra benefits that have come with the other partnerships, medical groups?

Reimers: Yes, certainly education, as fully as other regions. That can be done on an individual basis and physicians can even go away to educational meetings. We also have a good deal of internal education. Research--we have let our doctors know from the very start that we are not really equipped to do basic research, and that we can't do some kinds of clinical research because we don't have our own hospitals--that we would support research done in existing hospitals on an individual basis. I would guess that of 160 doctors we probably do as much research as any other group of 160 patient-care doctors do. We don't do as much research as training centers do, or medical schools. Our by-laws are set up to have research considered by the board and funded by the board. It tends, however, to be health-care delivery types of research subjects, something that we're good at, delivery of health care, rather than putting in a new heart valve or some highly technical research.

Chall: Are you always monitoring your quality of care?

Reimers: Yes. I think we have always done a good job of it. It's become much more formalized now, partly because of emphasis within the Kaiser organization, through its own board's demands, and partly through government, which requires that certain quality assurance be done. So it's a mixture of all of these things, including the medical societies, who have certain training minimums that one has to keep up. I think we do a good job in monitoring the quality of care.

Major Concerns as Executive Medical Director

Chall: Let's see, first let me check and see if I'm leaving something out. [Looks over notes] I can get too picky on some of these little questions that come up, but I did want to go over with you some of the concerns that you mentioned in your physician-

Chall: orientation talk, because it will give us an idea, I think, of how you operated as a medical director and what you felt your concerns were.* This is your list on "Living with Change."

Let me list for you ten worries that, you said, "probably took up 95 percent of my time as the EMD." EMD stands for--

Reimers: Executive Medical Director.

Chall: Of course.

Internal and External Problems

Chall: One of them I think we can understand, but "the interface with worried, suspicious and sometimes hostile fee-for-service physicians." Did that last a long time, throughout most or all of your fifteen years as EMD?

Reimers: It lasted, but it diminished in intensity from a very high, white-hot peak of criticism in the first few years, to one of begrudging respect.

Chall: But begrudging, huh?

Reimers: Yes, still. Yes. Of course, the fact that there is now a lecture named in my honor does show that some respect remains.** But even at that, there was a fair amount of grumbling when St. Joseph Hospital put a plaque of me in the hallway. "How come that SOB has become so much of a hero?" So it was a period of change.

I do think several things helped my image. One that I will always think helped was the resolution to "Go First Class." I think my continuation with the medical school in a teaching function there helped me. One of the things that doctors respect, universally, is training. The very fact that I had announced that I was going to give up the practice of surgery and I was going to the Harvard Business School to learn something about management, somehow excused me for some of the sins that I had previously committed, in their minds.

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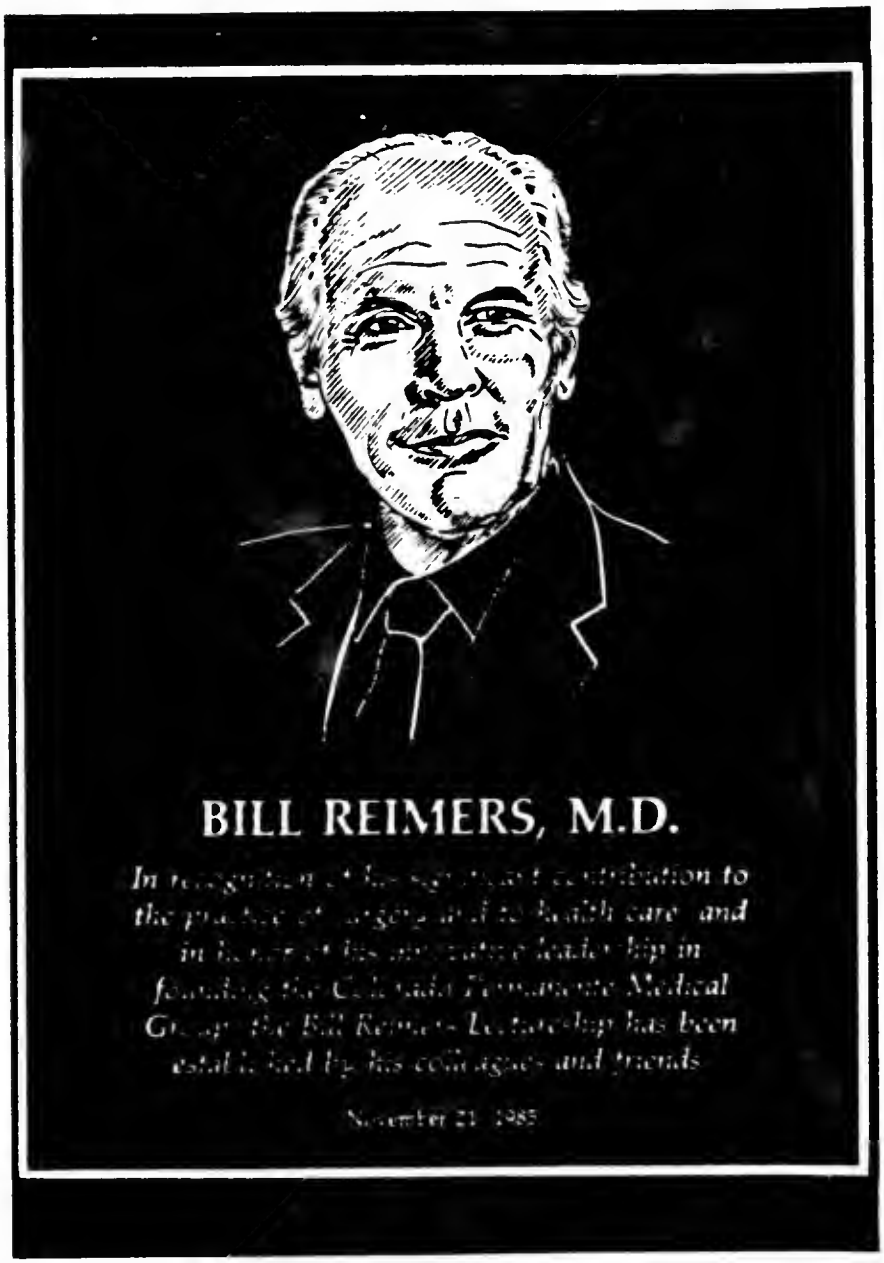
*W. L. Reimers, M.D. "Physician Orientation," April 12, 1985, 5.

**Dr. Bill Reimers Honorary Lectureship, established by The Saint Joseph Hospital Foundation and Colorado Permanente Medical Group.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In recognition of his significant contribution to
the practice of surgery and to health care and
in honor of his innovative leadership in
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November 21 1985

Chall: The second problem was "How to work in someone else's hospital." Maybe we've already discussed this.

Reimers: Yes, we did touch on this before. However there's one additional response I'd like tomake in regard to the use of community hospitals. That has to do with the attitudes of our own physician staff toward those hospitals. I emphasized these points to them:

1) St. Joseph is one of the finest hospitals west of the Mississippi. Kaiser would be hard-put to provide us with this kind of workshop for many years.

2) Don't assume that we will have a Kaiser-owned hospital during your career with us. It may be a long time coming.

3) Work out a compatible relationship with the rest of the St. Joseph staff, work on their committees, attend their meetings, meet their record requirements and earn their respect!

Chall: Actually the only difference is the way you're paid, isn't it?

Reimers: Yes, that's the biggest difference, though in a hospital there may be others that can be quite significant. The best example of this is the matter of block time in the operating rooms. In a Kaiser hospital it is not a problem because they run the whole show but at St. Joseph our surgeons receive no preference and wait as individuals at the end of the line to schedule their cases. This can lead to some inefficiencies, as you would suspect. I guess because it is a community hospital with a large staff to serve we should expect no favors, even though collectively we do bring in a great deal of revenue.

Chall: What happens if a drop-in patient comes into one of your clinics in an emergency and needs hospital care right away? Do you just transfer him to the hospital? It's not like going around the corner, or down the corridor. That would take some special action.

Reimers: Yes. But if he was an emergency he would be sent to the emergency room of the hospital. And then one of our people would pick him up, depending on what he needed. One of our surgeons would go over there if that's what is needed. If the patient was having a heart attack, he would be admitted to the proper ward and our cardiologist would see him promptly. And one of our largest clinics is right next door to St. Joseph Hospital. So we always have adequate staffing to see emergency work.

Chall: So you worked that out. "The recruitment of quality physicians." That's a problem that's ongoing.

Reimers: Yes. It's one that we have spent a lot of time doing. First of all, we made it a rule that we would hire only board-qualified specialists, preferably board-certified. But so many of these men are young, and usually it takes two years after one starts practice to take the certification examination. We expect them to take the examinations when they become eligible to do so.

After I left I heard that CPMG put provisions in the by-laws that new doctors can be differentially paid if they don't pass their board examinations. They're all board-eligible, and 75 percent of them are board-certified.

That's one matter of quality. Another is, of course, performance evaluations. These have become standard procedure, on an annual basis, for all doctors. Though increases in pay based upon these reviews is not yet a reality, the board has used this information to determine eligibility for shareholdership.

Chall: It takes, what, three years before they are eligible for total shareholdership?

Reimers: It's two now, I think. It's two in most regions, I believe.

Chall: "Control of outside medical costs." We may have gone over that, how you control those.

Reimers: Well, I don't know that we control them so much. Because, for instance, now, under Dr. Cole, they have adopted some mechanisms that we discussed years ago but never implemented, in order to hold down outside costs. A patient who is to be referred outside the system now, has to have the approval of the physician in charge of the clinic. It used to be that a physician could just get an outside physician on the phone outside the group and say, "See our patient." And I think that's preferable, if possible. But when you're in a financial bind such as they are now, they've had to tighten down on a number of things, and that's one of them.

You can also set up protocols and say, "Don't send our patients to an outside doctor unless a certain set of conditions is present." Another control is to, whenever possible, refer the patient to a doctor or a doctor group with whom we have a contract. And that will mean that we will get the service done at a cheaper price. Also the contract usually states that the patient will be brought back under our control as soon as possible.

Chall: Now you say that you had talked about it for a number of years, but not done anything about it. Was it a little hard for you to take the steps that were necessary after all the years you had been doing it your own way?

Reimers: My board would not accept what they later accepted when the competition became so tough. Earlier we had somewhat more relaxed rules that have since been tightened down. This is possible because doctors are in a much more competitive mood or mode than they were before.

Chall: "The internalization of specialty services"--I guess that means when you decide to take on our own specialists.

Reimers: Yes. We already talked about that some.

Chall: Yes, we did.

Reimers: One thing I would say about it is that just to be able to afford one is usually not enough. You'll either kill the guy off or--

Chall: He may not have enough to do.

Reimers: Well, you may not have enough work to keep two men busy. And if you only have one-of-a-kind specialist how do you provide relief for him? So usually, for practical purposes, a group needs at least two doctors in every specialty before it can consider internalizing that specialty.

Chall: "Member satisfaction, especially accessibility"--a great old problem.

Reimers: I have nothing except the usual things to say about accessibility. I think now we're getting much more sensitive about it, because of competition.

Chall: How did these kinds of problems come to you? You say that they took up the discussion--and we have't gone through all the ten worries--about 95 percent of your time. That means you were talking to physicians and partners and board members. Was your door open? Or was this board meeting agenda?

Reimers: Oh yes. Somebody would call me about--

Chall: Something that worried them.

Reimers: We would spend board meetings talking about one of those problem areas. We would spend every staff meeting talking about one or more of those subjects. Those subjects are subjects that won't go away. Take accessibility: that never goes away; it's always there. It might be great this month, and still, next month it's a problem.

Reimers: That's true of outside costs; you might think you've got it under control finally, and it slips out again. There are some problems you deal with on a one-time basis, and there are some problems you never get through dealing with. And I think that list would be those ones that keep repeating.

Chall: I guess so. Such things as impersonal care and rudeness: I suppose that really fits into member satisfaction.

Reimers: Yes.

Chall: That's a matter of training those front people, is that it? And/or doctors?

Reimers: Oh, including doctors, but not restricted to doctors by any means. It's the front people, the first-contact people. And they can be unbelievably rude. I experienced one last week that really embarrassed me. Despite all the emphasis that's been placed on this. I started up a committee that worked like crazy, and still is, on this subject of first impressions, politeness and so on. And they do work hard at it, but it's surprising how, again, it's a problem that won't go away. You can't solve it. You can do a pretty good job this month but find that under a little added stress certain employees will start being rude to patients again. The doctors less so, but when they do it, it's more devastating.

Chall: Are some people by training, by background, by however they grew up in their families, whatever it might be--do they tend to be more considerate, more polite to others than people who may not have had a similar background. Is it a matter of training on the job, or is it also a matter of what kind of background people come with? Can you determine who might be able to handle this better than another?

Reimers: I don't know, except I just instinctively believe that the way people are brought up as young people is the way they stay the rest of their lives. And unfortunately, we deal with the unions; we have certain obligations to employees. Once they come on, we can't fire them unless, you know, unless their sin is totally uncorrectable.

I'm not sure that the people who do the hiring have any way of knowing how a new employee is going to react once he gets on the job under a little stress. So it's a double-edged sword. I mean, it's one that the corporate world handles better than we do. Apparently, United Airlines and the hotels--people who make a point to be kind to other people--do a better job in selecting or training, or firing unacceptable people. And their problems, and their goal is to please people. Our goal is to treat people. That's unfortunate.

Chall: Yes, that's a difference.

Reimers: Some of the best doctors I've ever known have been rude in their own way. It's unfortunate, but it happens.

Chall: Does the criticism about personal care and rudeness--does that come back from patients, members?

Reimers: Oh, indeed. Indeed it does. It comes back in terms of separations, too, people who leave the program, and they don't tell you why. But if one takes an exit interview, you may find out why. That is a huge problem.

Chall: It is, really? It's not just down there as Number 7 because it's seventh in intensity?

Reimers: No. I think in this day and age it ought to be up near the top.

Chall: Is that so? Now what is "Provider satisfaction"? What does that mean?

Reimers: It's doctors, nurses, nurses' aids, physician extenders, and all the people who provide services. They require an esprit de corps, pride, satisfaction, lifestyle, pay scale, vacations, a sense of accomplishment and training, which all promote provider satisfaction. Most providers feel that after a year they deserve a period of further training in order to improve their skills. If they have a certain job, they don't necessarily have to stay there the rest of their lives, because the company will prvoide steps, career steps for them if they engage in certain training. All of those things have to do with what I refer to as "Provider satisfaction." A program of continuing education is important to doctors.

Chall: Are you using paramedics and--let's see, the other group--nurse practitioners, a lot?

Reimers: Yes.

Chall: Are they coming in?

Reimers: Yes.

Chall: And does that have any effect on doctors? Does it free them from less interesting work, give them more time for something that they think is more interesting within their specialty? Does that have problems?

Reimers: Both are true. There are problems. Whenever you bring in people on different levels of training you run into problems. It has taken years and years of legislation and training to decide what a doctor or a nurse should do. That's pretty well decided and accepted and they work pretty well together.

Now we bring in new types of paramedics who can do some things well but nobody really knows how much they can do or should do, and the law doesn't really state. So certainly the attempt was to do what you said: to not have overtrained people doing jobs that lesser trained people could do, is proper. There's a lot of economy there if you can figure out how to manage it.

Chall: Yes, and if they don't take more time than the doctor would have taken initially, I guess, on what they're doing.

Reimers: One thing about paramedics that is gratifying to me is, when used right, they are surprisingly well accepted by the public. So that's one redeeming feature in the paramedic muddle.

Chall: But both the doctors and the paramedics have to be satisfied--that's part of the "Provider satisfaction."

Reimers: The paramedics have to feel like they're doing something worthwhile. They're not just doing scut work, something less trained professionals can do.

Developing the Team

Chall: You've got another one here: "The turnover of regional managers and Regional Medical Facilities Managers." That's apparently one of the problems of the executive medical director, but is that really something that could be handled solely by the medical director? Isn't that part of the work of the team?

Reimers: That's right.

Regional Manager

Chall: We are ready to talk about one of the other problems that you had, and that was the "Turnover of Regional Managers and Regional Medical Facilities Managers." Now with regional managers--we've already talked about John Boardman who had to go back to southern California.

Reimers: Yes.

Chall: Then Carl Berner came in, and he was here for five years. I read a little interview that Carl Berner had with some people who were concerned about, oh, passing on the traditions of the Kaiser-Permanente culture, how it's done by manager and doctors and others. This was done in the southern California region.* Carl Berner said that, really, the years of greatest satisfaction in his career came when he was working here, because he had the sense of building something from the ground up. When he left in 1975 he felt that it was on its way, and it gave him a great deal of satisfaction.

If turnover was a problem, then, with respect to your relationships with these two people, one gets the impression that you were not responsible for the turnover.

Reimers: No, I was not.

Chall: It could be that you were not working happily or satisfactorily with the other members of the team, or they with each other. In the early days of the program, as you know, it was very hard for the medical people to learn to work together with the health plan managers and the hospital managers. The relationships had to be shaped--sometimes through trauma. They all had to feel that they were a team. And if there were any members of the team who simply couldn't get along with others, gradually these people were moved out until satisfaction came.

You came when the problems of team work had pretty well been ironed out in the Central Office and the regions. But still, coming into a new community there could be difficulties. Central Office sends them out, you have to get along with them. So how did that work out? That's saying a lot here to get an answer on regional managers and RMFMs.

Reimers: Despite the short period of time I worked with John Boardman, I found that he had a set of values to which I could relate very easily, so we got along extremely well. Incidentally, John Boardman was born of a medical family, and he had a good deal of the medical acumen in addition to being a health administration graduate himself. So he had special skills. And we were very close.

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*David Lynn and Susan Glasser, M.D., eds., "Kaiser Permanente Culture: Yesterday, Today, and Tomorrow," Middle Management Development Program II, April 1, 1985; Interview with Carl Berner, p. 5 of Berner interview [on deposit in The Bancroft Library].

Reimers: With Berner I had some problems in the team work area for only a few months, while making the transition. And after that I developed the best single relationship that I have had among any of these people. And why this is so, I don't know. I think one reason is that Carl had an extreme zest for life. He enjoyed what he was doing, it was contagious, and it made me enjoy what I was doing. We were making progress that was obvious. It was during this period that we went from the red to the black ink. We made some real progress in numbers.

I think, I will always think that to some extent we understood each other's boundaries better than any other combination that I have been part of. Carl was an attorney and was highly professional in his attitude toward his profession as well as that of others. So that we had fewer problems of venturing onto each other's territory. I believe that led to the mutual respect that continued until his death, long after he had left here. We were always happy to meet each other. We golfed together, or whatever. So my relationship was excellent with Carl Berner.

Do you want me to continue?

Chall: Yes. Now he left because they needed him in Oregon, as I recall. So he didn't leave because there was any problem here?

Reimers: No. Neither of these men left because of any difficulty here.

Chall: Yes. Then the next person was Max Brown.

Reimers: Well, let me just say, right out of the box, that we may have to re-word in the final draft what I may say about the Brown/Reimers chemistry.

Chall: All right.

Reimers: While Max was in Colorado--

Chall: Which was only two years.

Reimers: I never established with him any kind of the same relationship that I had been able to with either Boardman or Berner. In fact, we had some rather difficult times. I always somehow felt that Max was intruding on my territory, and resented him for it.

Chall: What does it mean to intrude on your territory? How might have that been done? Just so we all understand "territories" here.

Reimers: Oh, in criticizing outside medical costs, for instance. We both might know that these costs were higher than they ought to be. It's my job, my judgment, that would be relied upon to bring them

Reimers: down in an orderly way, because he had no medical background. But still, in that area he would assume as much authority as I. And I felt that was my territory.

It's interesting that on a personal basis we probably have had more fun together than any other two men we've had here. But we couldn't work it out as well on the job as we could on the golf course, for example. An example of that is, after he went to Texas, he and I became quite good friends. And whenever we met, we met with genuine happiness, I think, wishing somehow that the difficult period we had had together had not occurred. We were regretful of the fact that we didn't do better together.

Now when you ask why he left, I think it was a matter of providence for all concerned. He had an opportunity to leave Colorado and go to Texas in a lateral shift, still as regional manager. He is a Texan, he understands the Texas style, and they needed him in Texas. I understand he has left again now. I don't know the story about that. But Jim was aware of the fact that Max and I had had some difficulties. We would eventually always work them out, but we sometimes left a small trail of blood behind us.

Chall: Is that right? It was that much of a problem?

Reimers: A couple of times a year, particularly during budgeting times, it was brutal. We didn't seem to have mechanisms that we could use to bridge the gaps between us. I never had that experience with anyone else, but I will accept my part in it as being an oil and water situation. It obviously didn't work very well.

Chall: He stayed just for the two years. In 1978 Wayne Moon came. As far as I can tell, he was here through 1984. Is he still here?

Reimers: No, he's gone. He's gone to northern California. He's the regional manager of northern California. And as far as I know, went because he was needed there. There was nothing precipitated it here, that I'm aware of.

Chall: You had a long experience with him, because he was here for, I think six years, from 1978 to 1984; at least through 1984. Was that a compatible relationship?

Reimers: It was compatible, and we both tried hard. It was not always enjoyable. I felt, too, that Moon wanted to be more influential in running the medical group than I was willing to have him be.

Chall: This can be a problem, this team arrangement, can't it?

Reimers: Yes. You know, when challenged, we would both back off to safe territory. But we didn't naturally know how to deal in the other man's arena too well. And still, because we were both dedicated

Reimers: to our jobs and to our team, we found a way to do it. But it wasn't easy; whereas with some people it was easy and was fun. With some people it was tough and it was not fun.

Chall: And again, it was his interest in the medical side, is that it? His concern?

Reimers: Yes, that's putting it perhaps too mildly, because he should have had an interest. He should have had a concern. It was that he wanted to exercise a more direct control over the medical group.

Chall: Control?

Reimers: Control!

Chall: And did that, again, have something to do with cost? Was that the concern? Or was he interested about the doctors and how they operated, how your group met, and how it overcame some of these problems that we've talked about?

Reimers: Cost was the big factor. Competition was beginning to rear its head. The hospital question was paramount. He was determined to build a hospital. As a matter of fact, to this day I've heard he believes the biggest mistake that was made in this region was, after he left, for the building of a hospital to be cancelled.

Chall: Oh, I see. One had already been planned, was on the drawing board?

Reimers: Oh yes.

Chall: Contracts let?

Reimers: Almost.

Chall: Is that so?

Reimers: Almost.

Chall: How did that happen?

Reimers: When the new regional manager came, [David] Lawrence, I was already pretty much out of the picture. If you read some of the things I've written, I have always defended the belief that we could survive without a hospital, and that maybe this was not the time to build. I think that joint management in Colorado made the right decision eventually, because I think that they are much leaner, much tougher, and they'll be able to meet the competition. If they build the 100, whatever, million dollar hospital that was planned the effect upon our dues rate in the marketplace would

Reimers: kill us, I think. When there are empty beds all over town, how do you justify building a new hospital? There's such a thing as civic responsibility. That was one of our problems.

Wayne was determined to bring a hospital to this region, and I was dragging my feet, finally accepted it and in good faith helped to plan it. But we had to go through certificate-of-need hearings to which we all went in good faith. We weren't trying to undercut each other on this score, but that was one area in which we didn't totally agree. Another was the physician competition business: doctor's compensation was an area of difficulty that we never could seem to work out. Wayne felt he should have an authority equal to mine in this area.

Of course, you're hearing it from only one party, only my side.

Chall: That's all right. There's no valuable history if we pass over the issues. At least they are out to be considered.

Reimers: I feel that Wayne resented the doctors' close relationship to the hospital, which kind of left him out of the picture. In other larger regions the hospital is part of the health plan. Here, it's a third party. So it left the health plan in a clumsy position, when doctors were getting along so amicably with their competitors in the same hospital. Maybe that was one of the reasons why he wanted to build a hospital--to force a more even-handed relationship between the two teams. I think he felt that our side of the team was overloaded against him. Something in this inter-relationship led to some chilly feelings between, not only us, but our major subordinates. The health plan, the medical group, and other members of each group, felt this tension.

Chall: Well, it's interesting to know how the teams work, if they're working, and what might lead them not to work. Your region is different.

Reimers: It's true.

Chall: You do not follow the code.

Reimers: More than anything else, it requires trust. And once that trust is broken, it never quite repairs itself again in the same way. I suppose there are other analogies in life to that. But I think eventually the health plan has to trust a doctor for medical care. In the last analysis, an untrained group of doctors has to look to the health plan for basic financial and fiscal guidance. And if you're both going to challenge each other on every one of these points, one of them is going to come out a winner each time and one of them is going to come out a loser. Well, teams can't work like that. That's part of the problem.

Chall: And that's what makes the Kaiser-Permanente plan work, if it's going to work.

Reimers: That's right.

Chall: And the reason it has worked, I think, over the years. But it hasn't been easy.

Reimers: I think that's one of the reasons why Berner and I worked so well together. I knew better than to tread on his turf, and I respected him for involving me whenever he could. But he would eventually make the decisions in his field. He didn't do it in the dark. He expected the same thing of me. So it was a mutual respect at a professional level that made it possible, that made the best working relationship I've ever had. And many other people say the best one they've ever seen. So whatever it was, I'm proud to have been a part of it.

Regional Medical Facilities Managers

Chall: Now what has been the problem with the regional medical facilities managers? I don't see one coming into the picture until 1978, when Kathryn Paul came in. She was here three or four years. [1974-1981] Then June Finsterle came in. And she was here two years. [1982-1983] Then there was Christopher Binkley. [1984--] Has there been a reason for this turnover? What do these regional medical facilities managers do?

Reimers: The regional medical facilities manager ("Rim-Fim in local parlance) is another one of those schizophrenic jobs created by Kaiser that involved two bosses. The RMFM reports equally to the EMD and the regional manager. He manages all direct patient care facilities in the region, excluding administrative space, optical dispensing, laboratories and storage. Each of the clinic administrators reports directly to the RMFM.

Through the years there has been some turnover in this position, primarily due to promotion to better jobs. It is a job that requires considerable management skill and so, is a springboard to some of Kaiser's top positions. Because of this there have been five different RMFMs in Colorado since 1969: Irv Morgan, Dave Rodeffer, Kate Paul, June Finsterle and Chris Binkley, in that order. Due to the peculiarities of the dual reporting role, the widespread locations of our facilities and the lead-time required for facility planning a turnover in this job can be quite upsetting to the region for several months. I know of no easy way around this problem.

Chall: Why do I have this big blank from 1970 to 1978? I've gone through all of the annuals and never saw a name. Was there another title for that position?

Reimers: The first person in 1969 was Irv Morgan. His title was clinic manager at that time. He left to return to southern California after Carl Berner came and the new title of RMFM was established. Since then this job has been filled by Dave Rodeffer, Kate Paul, June Finsterle and Chris Binkley, in that order. I don't know the exact years they served in this position.

Chall: So those people were responsible in two directions?

Reimers: Yes. That was another problem. But it was one of these situations, again, where you have two bosses, and that never works very well.

Chall: Yes, that's hard.

Reimers: I think, in fact, because the future of these RMFMs depended upon the health plan, that left me as sort of a second-rate parnter in this, in this dual-boss relationship too. Our doctors felt that way, definitely. So it wasn't an ideal setup; on the other hand, it was better than having no control at all.

Health Plan Manager

Chall: Now we haven't talked about the health plan manager. They didn't change very much. It was William Kneedler for many years [1971-1979], and now William Green [1980--]. They're in the center--at least one diagram I saw of the Kaiser Permanente is a triangle with the health plan in the center of the triangle, because there wouldn't be a Kaiser Permanente plan without the members.

What was your relationship with the health plan manager, and his with you? How did they fit in here?

Reimers: Well, first of all, my relationship with the two that you mentioned--

Chall: Kneedler and Green?

Reimers: I have had good relationships with both of them. Now, how did I relate to them? Well, they were, of course, in charge of meeting the membership forecast, because, if we were short of members, we were short of money. And since I had committed money by hiring doctors, I had a problem. On the other hand, if they brought in too many members, then I didn't have enough providers to serve

Reimers: them, and we got into accessibility and service problems. They, in a sense, sat in the middle in that respect, too. They couldn't win either way. Health plan managers had to hit the forecast right on the button, or they would get criticism from the doctor group.

So they were sitting on the hot seat, and of course they had to project a whole year in advance how many members they were going to get. Some years we got so many members we were swamped, and other years we didn't get enough members and we were overstaffed, and underfinanced, because we were paid on a per capita basis. So we dealt with them closely in regard to membership forecasts, membership drives, etcetera.

The other area that the health plan manager had control of that we were sensitive about was the membership complaint department. We, of course, harvested all the blows. The members don't complain about the health plan, they complain about medical service they don't get, get late, or get rudely. The medical group took the brunt of criticism from the health plan for complaints that were collected through their membership service deparmtent. So it was important that we deal closely and understandingly with each other in this sensitive area, and we did. I think we had a good relationship with both of those men. [Kneedler, Green] And, of course, they answered totally to the regional manager, so that their relationship to me was only informational, so to speak. I didn't have the job of being their boss.

Chall: Or fighting for your turf.

Reimers: Right.

Chall: And then finally we have "Growth/competition/cost to members."

Growth, Competition, and Cost

Reimers: Growth, competition, and cost to the member? Well, that's really all one ball of wax. I will say that our problem early was that nobody recognized what Kaiser Permanente was. Nobody wanted to buy us. And finally, through small gains, we made our way into the marketplace and grew, well, grew rather satisfactorily during the first ten or twelve years.

Despite this--it was obvious that on the horizon were some dark days, because the place in the market that we had to ourselves was no longer our private preserve. And with the passage of the HMO act, and the IPAs [Individual Practice Association],

Reimers: and PPOs [Preferred Provider Organization] that were coming in, it really meant that we wouldn't be protected any more by the capitation concept. We will have to produce better quality care to compete. We will also have to produce better accessibility than our competitors to maintain our position in the marketplace.

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Reimers: Some of my former associates have remarked, "Bill, you must have been clairvoyant to see all this change coming. You've got it made now but my practice is falling apart." Private practitioners that I know and have known for years are becoming scared. They are frightened that they will lose their practices to new forms of delivery. So they're joining up with something, almost anything, another HMO, an IPA or whatever. The competition is getting brutal out there and some physicians resent me for it. Maybe I <u>am</u> another Bill Dorsey?

Chall: How do you think some of these are going to work out? First, there's an attempt, on the part of many of them, to want to make a profit for their group, which is different, in a way, from what you [Kaiser Permanente] were doing. And secondly, because there's no medical training for this model. Do you see ahead the fact that some of these upcoming models might give you competition now, but that they might ultimately fail? Or maybe they will be a better model than what Kaiser has been. Can you foresee what's going to happen with them?

Reimers: Oh, I don't have any firm ideas. I do think that one thing is now proved by us and by a lot of other people. The old genetic code has been broken, and a health plan doesn't need a hospital. It may work in some instances better, but you don't absolutely need a hospital to make this work. As a matter of fact, the costs may be so great that you can't build a hospital and stay in the market.

I think the IPAs, which are really a combination of fee-for-service and capitation, are going to fall one way or the other. I don't think one can be that schizophrenic in his practice. You can do it temporarily, maybe. But I think that physicians will eventually gravitate to fee-for-service or prepayment. I do feel that the private world is very sensitive about their own productivity, and Kaiser is relatively insensitive to productivity by individual providers. So Kaiser Permanente medical groups will have to face much tighter productivity demands than they have in the past, I think.

Chall: Does that mean scheduling more patients? Is that what you mean? Longer work days, or a little harder work days?

Reimers: Yes. They're going to have to sacrifice some of their lifestyle, and their work week is going to be longer. Also, very likely their incomes are going to be less, in order to get dues rates down to a competitive level. And if doctors want a lot of fancy lifestyle, they're going to have to pay for it by being paid less, because we haven't been that productive. The reason that our dues rates were more reasonable through the years has been primarily because of the way that we used hospitals. The money we could save on hospitalization was enormous, and we could do a lot of very attractive things with that money. Amongst them, lowering the rates so we were the only game in town. A lot of that advantage is gone now. I think that our doctors are going to face a tougher row in the future.

Of all the forms of competition we've seen, the one that's going to be the toughest for us to compete with is not other HMOs, because we have a leg up on them, in terms of experience and so forth, but it will be the PPOs. PPOs work on the basis of discounted fees, whether it be those of a hospital or of a doctor. And they can discount those fees as low as they want to and still survive. We may be unable to meet that competition. Also they can subsidize the HMO part of their operation from their private practice, but we have no private practice revenue. Of all of the new schemes, PPOs are the most flexible and they're the fastest growing. PPOs also worry me because they don't have to sustain a big organization like we do. Their overhead costs can be kept very low.

Another thing that looms large are the big for-profit organizations, AMI [American Medical International] and others, who, together with the discounted-fee advantage, can in fact lose money to remain competitive. We have only one source of revenue. AMI has dozens of businesses, hospitals, all kinds of insurance and other things. It's possible for them to subsidize their programs out of the more profitable ends of their operation, putting us in a very difficult competitive situation. All that sounds gloomy. I don't think it should be. If we tighten our belts and become more productive and become more sensitive to patients in terms of kindness and access of care and that sort of thing, we will survive. I do think there are a lot of these newer forms of health care that will eventually fold, or merge with others, or whatever.

Chall: A real shaking out. Well, it will be interesting to see what happens. I had a couple of questions that also related to your speech here, though not your list of ten worries as EMD. One of them had to do with the Colorado Permanente Medical Group board. Is it too political by having six out of seven voting positions filled by election? You say, "This may not have been a problem, but I predict that someday it may cause an instability of the

governing body that will take considerable political courage to correct. Other regions have avoided this vulnerability through their original by-laws. I regret that we did not."* The question that I have is, how come you didn't copy the models that were already out there in northern California and southern California?

Reimers: We did. We did copy southern California, who were our sponsors. We should have copied northern California.

Chall: Oh really? I didn't realize the difference.

Reimers: There's a tremendous difference. And southern California, for a number of years, has been trying to change more to a northern California style. Northern California Permanente runs a tight ship and their physicians are better off for it.

Chall: Dr. Cutting must have had something to do with that, and all those pioneers. In fact, they had to loosen up on it a bit; it was very tight. So you did copy a model. Was it difficult for you over the years?

Reimers: No, not really.

Chall: That's because you were there?

Reimers: No, it is because the group is still quite small and manageable. But it will be a problem in the future, I think, because the elected people won't have courage enough to make the tough decisions. They're like congressmen--too worried about the next election. It's all right, it seems to me, to have both political and elected offices, but not for elected positions to predominate.

There are not many corporations that can run that way. Usually there are a few shareholder members on the board and a majority of management people who are responsible for running the organization. You can fire inept managers but what do you do with inept elected board members?

I think CPMG's current model is potentially unstable. I wish that we had not followed the southern California example, but, after all, they were our sponsors in 1969-70.

Chall: How would it change if you were going to follow the other model here?

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*Reimers, "Physician Orientation," 7.

Reimers: Well, the model I preferred was voted down several times over the years. The basic flaw, in my opinion, of our current board is that only the EMD and the elected (political) members having voting privileges. I feel strongly, as they do in northern California, that our management members (Physicians in Charge of our major facilities) should also have votes on the board. Those who have the responsibility for day-to-day management should be involved in the decision making of the board. To be present at board meetings without voting power effectively emasculates them. For this not to occur also allows the EMD and his management team to avoid responsibility merely by declaring that they were outvoted by a political board, who have little awareness of management problems. A CEO and his management team should not be able to escape accountability in this way.

The most regrettable feature of all of this is that because of the politics involved no improvement can be expected in the future. Such a change would have to survive a board vote in order to submit this reorganization recommendation to the shareholders--probably a political impossibility. I was unable to get such a recommendation out of the board, though I surfaced the issue repeatedly over many years.

Merit Pay

Chall: Now what about the issues of merit pay? I think in some of the regions they do have merit pay, don't they? And you never were able to get that across either?

Reimers: That's right. Again, it could have been done at our beginning but we followed the southern California style. Northern California has a very sophisticated merit pay system, and it leads to much better productivity than the southern California pattern. I got merit pay past the board one time, but we had to vote it out--because a committee made it totally unworkable. The promise was we would bring it back in a more workable form the next year and that was politically impossible. So we had a lot of hassles over merit pay.

I think it's very unfortunate that we do not have it, but I think they might now--under the strictures of the current economy and the need to get more productivity--the group might be willing to reconsider merit pay. I hope so.

Relationships with the Central Office

The Kaiser Permanente Committee

Chall: Now, I have a couple of final questions here. I was interested in how you related to the rest of the Kaiser organization, and that would have been through the Kaiser Permanente Committee. You organized here just about the time the committee was really formed. How have you found the meetings and the work of the Kaiser Permanente Committee to be?

Reimers: The Kaiser Permanente Committee was formed, as I understand it, primarily to face the issue of expansion to Colorado and to Ohio. So it was formed only shortly before Sam Packer and I joined it. We saw it evolve, and saw it mature through the years. I think it's the standard bearer of this entire organization. Because it was primarily a policy-making body that all respected, and the decisions that came from that body were taken back home and whenever possible sold to the local region and implemented.

It started, of course, with Cliff Keene as its chairman, its first leader. After that we had rotating chairmen, but the agenda was pretty much determined by the president. I found it to be an extraordinarily good body. It brought issues to the Central Office so that they could hear from various parts of the country what the problems were. And we all could hear things that took a lot of specialized research to develop, such as legislative programs. We all had an opportunity to hear those discussed at length. So the issues were all brought there, and many issues were decided there on a policy basis, but left up to the regions to implement in their own autonomous way, which is unique to this organization.

The local autonomy is the strength of the Kaiser Permanente program, as far as I'm concerned. The fact that the Central Office appreciated that was, perhaps, due to the fact that Jim Vohs came from one of the regions and realized that the Central Office could not dominate the program from the top down. But it could still organize at the top to support all of the various regions. I just have to say that, without exception, the Kaiser Permanente Committee meetings were well run, they were very valuable, and they were a key, I think, to much of the success of this program.

Knowing the Pioneers

Chall: Very good. In the course of your meeting with the committee and getting acquainted with other people, I guess, in the Central Office, and in the other regions, did you get to know Dr. [Sidney] Garfield at all?

Reimers: Only superficially; pretty much through talks that he gave. He was nearly gone from the scene by the time I came on.

Chall: Did he still have an aura around him as the founder that people gave deference to?

Reimers: Yes, he did. And he remained quite articulate until his death.

Chall: How about Dr. [Cecil] Cutting?

Reimers: Dr. Cutting is probably my favorite of all people in Kaiser Permanente. Without question he was my confidante, my advisor, and my older brother in many issues. I never got anything but very good advice from him. And I wish that we had been started by his region, because I think we would be a better region today if we had. This may not be proper to come out in print, but that's the way I feel about it. I have felt extremely kindly toward Cece Cutting all the time that I've known him.

Chall: Did you get to know Dr. Collen, who has been so immersed in the research area?

Reimers: Recently, and not very substantively.

Chall: He's one of the other pioneers. How about some of the management side pioneers: Mr. [Eugene] Trefethen.

Reimers: I don't know him well. There's an aura of respect that surrounds him. He was always very kind to me personally. I always felt, in my own mind, that much had been said to praise the Kaisers, but that really much of the credit should go to Trefethen. I never knew the old man [Henry Kaiser], but I suspect that he [Trefethen], was a key to that organization. And certainly, I think, he was with Edgar.

The Board of Directors and the Staff

Chall: When the board comes to the regions, occasionally, for its meetings, then you do get a chance to meet the board?

Reimers: Yes, and, of course, we went to board meetings. We went to three or four board meetings a year, too. This started with Cliff Keene. He felt that the board members should get to know what he called the top leaders in the regions. I understand, more recently, that they are thinking about cutting down on that, the numbers that go to the board meetings. Perhaps that would be helpful, I don't know.

Chall: There are probably too many of them now.

Reimers: But I got to know the board pretty well by going to those board meetings.

Chall: And how did you feel about the board members?

Reimers: Generally I felt they were very well selected. I think there were a couple of weak sisters in the original group. But I think progressively, through the years, Jim Vohs strengthened the board by excellent appointments.

Chall: Because you can look at that now, from you stance as a trained executive and see how boards operate? Or can you?

Reimers: Well, I'm really not that well trained. But I do know that some of them are more effective than others.

Chall: That's true of any board, I'm sure. And Scott Fleming? I just put his name down here because I know that he has been around in the Central Office there for many, many years, since the early days, and I'm sure has dealt with all of you.

Reimers: Yes. Very helpful in all ways. It's generally thought that he is more successful in his various positions in the Central Office than he was as a regional manager.

Chall: What's your assessment of Clifford Keene? I don't know how many years he had before he retired after you came in, but there had always been some lack of total friendship, trust, between the old-time regions and Dr. Keene. But you saw him functioning as the executive director.

Reimers: Yes. I thought that he was a better man than he was generally given credit for, and that, in fact, some people benefited by using him as a scapegoat. That's not to say he was the best man that ever occupied that office, but I think that he got a bum rap out of it, to some extent.

Chall: So you did respect him then as a manager?

Reimers: Yes, I did.

IV THE COLORADO MEDICAL CARE PROGRAM: SOME FURTHER THOUGHTS*

[Interview 2: April 8, 1986]##

Publications for Staff and Members

Chall: Yesterday I was going to ask you whether the medical program here put out information of this kind. [Showing Reimers various materials published in northern California] Whether you did publish as they do in northern California and in the other regions.

Reimers: Yes, we do. We have basically two sets of publications, one for our members, which has a lot of health hints in it.

Chall: Yes, that's that one? [Planning for Health]

Reimers: Sort of a planning for health type. And then the other one is an instrument that is meant to be read by the employees of the organization.

Chall: Yes, which I think is like this one? [Reporter]

Reimers: Right. Issues, employees--so that I think we have almost the same concept here.

Chall: Yes. And that's considered an important part of--

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*This interview was held following a taped group discussion with Drs. Reimers, Toby Cole, William Green, and William Allen, April 8, 1986. The tapes are on deposit in the Microfilm Division of The Bancroft Library.

Reimers: Yes. Unquestionably, it helps to create a culture, a local culture as well as an identity with the program, both by employees and patients. And of course a lot of helpful health advice is given in the Planning for Health, so that this can be of very practical importance to the family, too.

Chall: Now you have an editorial staff then here in your own central office?

Reimers: Yes.

Chall: This isn't part of the medical group?

Reimers: No, it isn't.

Chall: It's health plan/hospitals?

Reimers: The medical group are asked to contribute the specific items occasionally. The editoral staff select appropriate medical subjects. Other than that, both publications, and even other special ones, are under the control of the health plan. So the editorial effort is a health plan function.

Chall: I see. That you had almost since the beginning?

Reimers: Yes.

More on the Recruitment of Medical Staff

Chall: When I told you this morning that I thought I'd left some questions out yesterday about the recruiting of doctors and medical staff, I was interested in whether there were minorities and women on the staff, and whether you went out to seek them, making sure, as you said, that they were well-qualified physicians.

Reimers: Right. And, of course, all of them had to be interviewed, and we had to see their curriculum vitae, as well as to check their references, which we always do by phone. We do not rely on written reference because we don't trust them. People will say things on the phone they will not say in print.

Primarily we uncovered these people by advertisements in high-quality medical journals, except for local people. And then, finally we became well enough known that recruits would be referred to us. Such physicians discovered us by their own efforts, so to speak.

Chall: What about the recruitment of women and racial minorities? Have many applied and been accepted?

Reimers: CPMG has always been an equal-opportunity employer but has had great difficulty attracting well-qualified blacks. They are in great demand nationally. During my tenure the same was true of Chicanos. With women it's a different story. The numbers of well-qualified female applicants has increased dramatically. Women now comprise about 30 percent of the CPMG staff.

The Mental Health Program

Chall: What about psychiatry here?

Reimers: We provide it.

Chall: You do?

Reimers: Yes. We have a mental health plan. We do use paramedics and social workers along with psychiatrists in an integrated program.

Just to add one more cap to this. The region has distinguished itself, unquestionably, by the development of a number of paramedics in many different fields, hoping to find the most economical way to treat patients. One of the reasons we did it was because of the shortage of doctors years ago. Now we have a flood of all types of providers. And it's my current feeling that we overuse paramedics in this region. It's time to reevaluate how best to use them. I'll just stop it there. But we do use paramedics in the mental health field.

Chall: So those people would be psychiatric social workers, rather than psychiatrists or psychologists with a Ph.D.? You're calling those paramedics whereas we might just call them psychiatric social workers with an M.A. degree?

Reimers: Right. Well, we're calling the Ph.D. psychologist a paramedic too, because he's really not a psychiatrist.

Chall: I see.

Reimers: We've lumped them together. A psychologist, presumably, has a doctorate, but he's not a physician as such. But we tend to use them interchangeably depending upon their different individual strengths. So we try to make a blend of these various providers. And we have a number of all kinds--psychiatrists, psychologists, social workers; and there are nurse practitioners in this field also. It's a mixed bag.

Chall: Do you use psychiatric social workers as medical social workers, to help families who have patients in the hospital with terminal illnesses, or children who need special care?

Reimers: We use them minimally. Actually, we use the hospitals', because we don't have our own hospital. We use the ones that are part of the hospital system.

Chall: I see. Because they do have them now in most hospitals.

Reimers: Oh yes; they have them. They have them in the hospitals we use. And those, tied in with home health care, makes a nice package of continuity by working through St. Joseph's. So rather than split it up and have that all internalized, it has worked out best for us to leave it all to outside people.

We have had pretty good results in the recruiting area all through our history. We've had some slack periods in certain specialties. And as Dr. [Toby] Cole mentioned, within the last two years we've had virtually no difficulties. Now that's due to a number of things: Competition, oversupply of doctors in the country, the cost of setting up a private practice, the cost and uncertainty of malpractice insurance, and the whole movement toward group practice. Physicians are moving out of solo practice into group practice nowadays in large numbers. So it's easier to recruit than it used to be.

Chall: Do you think that there is really an oversupply of doctors? Or is it just an oversupply of doctors who want to be in certain urban settings?

Reimers: I think yes to both of your questions. The biggest problem is maldistribution. But I think the figures now clearly show that there is already an oversupply of doctors, and when they all come out of the pipeline in the next three years, we're going to have a significant over-abundance. I happen to know of this number: that for doctors in patient care, there has been already a two-thirds increase, an increase of two-thirds over what the number was fifteen years ago, while our population increased only by 15 percent during that same period. The ball began to roll with the legislation of 1973-4, when the federal government got into huge funding into this area. This increase in medical students is now beginning to show up with mature doctors, well trained in all specialties. So I do believe there is an oversupply of doctors.

One other point is that coincident with the doctor glut has been the development of paramedics, who are filling up the slots as well. So we are rapidly becoming very heavily served in this country by health-care practitioners--of all types.

The Cost of Filling the Need for Medical Care: Medicare and Medicaid

Chall: And yet there are certain areas in the country where people aren't getting proper medical care and nutrition, dental care and all the rest--that seem to be not getting it at all.

Reimers: That's either a matter, I think, of geographic maldistribution, or funding maldistribution. The Medicaid population in some states is well funded; in other states is poorly funded. It's very unevenly funded. Contrast that to the Medicare program, which is evenly funded nationally; it is totally federally funded, and it is well funded; some people believe too well funded. But the two programs are not equal in that regard.

I think the biggest under-served population in this country are the indigents. That is not well handled in most states. Some states do better than others.

Chall: And the HMOs aren't going to take up that slack at all, are they? They have to live on their own resources.

Reimers: Well, that's right. They can't subsidize the indigents without putting an extra burden upon their paying members. So unless further legislation develops which allows the government to toally fund Medicaid as well as they do Medicare, the poor are not going to get treatment easily.

We do well on Medicare fees. We serve the elderly very well. We don't serve the Medicaid people very well. We have a few demonstration projects with Medicaid in other regions, as you know.

At the moment there are very few HMOs in the indigent area because of two reasons: one, poor funding, or uneven funding; and the other is the eligibility problem. Once you're past sixty-five you're always in the Medicare population. But people may move in and out of Medicaid, across the Medicaid line maybe several times a year. It's an administrative headache to try to keep up with these people, because you might have them as a member one month and not the next, and so on. It's a very fluid population.

Chall: But with so many additional doctors on the horizon, that would be one way for them to be productive, if we get to that point.

Reimers: If we get to the point--

Chall: --where they're just stepping all over each other, and no place to go.

Reimers: Yes. There's a price to pay for the overproduction of providers. I personally believe it's questionable that the overproduction of health care personnel is cost-effective. I believe, and many others believe, that it is inflationary. So if we're going to try to hold down health care costs, producing more and more health care providers will not help because they will find something to do, and they will charge for it.

The health care field is very flexible. You talk about a flexible market--health care is it. You can start treating almost anything and keep busy doing it. And not all falsely. Problems that were never treated before; new techniques are developed. So that increased production of doctors--and they found this out in China, too--is not necessarily helpful in delivering health care. It's strongly inflationary.

Chall: That's an interesting point of view.

Reimers: Then you wonder whether you really increase access by having too many providers. I think organization is the answer, not just members.

Chall: Usually we look at it in terms of supply and demand, but you're saying it doesn't work that way in the medical field.

Reimers: No, I think it tends to not work as smoothly as it does in other areas, where the matter of supply and demand is finite. Whereas the demand for medical care is not finite; it is expandable to almost any imaginable amount.

Someone must decide what is necessary and what is not necessary. And that is very difficult to do by regulation. Most governmental regulations have failed.

A good example is the control of hospital beds by certificate-of-need legislation. It produced exactly the opposite result because everyone wanted to build their hospitals, and to get their equipment ordered before the government edict went into effect. That defeated the purpose of the legislation. Here in this very city we had many thousands of extra beds and yet certificate-of-need permits were being approved. So I don't think regulation is the answer. I think it has to come down to self-regulation within the industry; people who know what they're doing, who know what they're talking about and who are limited by financial feasibility--not federal funds.

Dr. Reimers' Early Interest and Activity in the Economics of Medical Care

Chall: I didn't discuss this with you yesterday, but I noticed from reading some of the material that you gave me, that your concern about regulation brought you, in a sense, into the Kaiser program. I guess I just didn't follow up on why you decided to come in; then I read that you had been studying this problem of economics and regulation in the sixties.

Reimers: Yes. Medicare and Medicaid were passed in 1965 and implemented in 1966. In 1966 I became seriously involved with the medical societies in social-economic study committees who wanted to learn how to live in this new environment. What would we do to meet these new laws?

Well, almost every state in the union started developing the so-called relative value scale. A relative value scale, basically, is a design in which a certain value is placed on every medical procedure. A certain numerical value, not dollar value. For instance, a gall bladder might be given 250 whereas an appendix would be given 125. So in a relative value system, a gall bladder operation would be worth twice as much as an appendectomy. The idea was that a conversion factor would be determined by the doctor, by an insurance company, or by someone else paying the bill. The final bill was a result of multiplying the relative value by the conversion factor, which was variable.

What that did was to prevent the fixing of fees. For generations, back to the Greeks, the doctors have resisted fixation of fees. Every doctor wanted to be able to charge his own fee, and he wanted it to be variable depending upon the patient's ability to pay. Well, they could still do that with a relative value scale by just changing the conversion factor.

It was that that I helped develop in this state. I became very aware of the fact that the profession was getting into trouble because of high health care costs and that I, along with a lot of other people, felt that we would end up with a British system.

Also at that time, if you remember, in the early sixties, we had a very liberal Congress, a liberal administration, and you probably recall that there was much talk about national health plans and so forth. Not only was I worried, but I wanted to be in the position to help control and devise new systems, rather than to totally socialize the system. And that's how I got started in medical economics.

Reimers: And I also had a feeling that we would be run by bureaucrats and administrators unless doctors learned how to administer, learned how to manage. So I became very interested in management, as I still am. And I'm proud of whatever these efforts have been to teach doctors management skills. It's paying off all over the country, because doctors are becoming involved in management.

Chall: Yes, and if they don't, they're going to suffer great losses in whatever groups they set up.

Reimers: Right. And not only that, but they will suffer--and I think most doctors think the profession will suffer--if they become just hirelings. There was a good deal of self-service in that position, but I do not think self-service is in itself evil.

Chall: But you thought and continue to think that this was the right way to go, if the change had to come--the Kaiser medical care program?

Reimers: Yes, I did. And I'm pleased that my wife and others encouraged me to make the jump that I wanted to make.

Plans for "Retirement"

Chall: Yes, that's quite a change. Now what have you been doing since your retirement? I noticed the medical people in the Kaiser programs that I've known so far don't really retire. They may leave their particular group, but they don't really retire. Often they carry out assignments within the organization. You've been out for just a year now, haven't you?

Reimers: Yes. What you probably don't know is that, starting in 1980, I began to have a back problem which has continued to deteriorate. This has forced me to separate myself from the medical group--to take an early disability retirement.

My health has stabilized somewhat in the last year, so that I'm beginning to be more functional, which permits me to do some writing. I've been asked to write a couple of papers for a China trip this spring. [April 1986]

Chall: What are they about?

Reimers: One is about changes in practice patterns among physicians in America. Chinese physicians, I understand, are very interested in our practice patterns. Of course, we've undergone some very great changes in recent years. HMOs, PPOs, IPAs, group practices, all that.

Reimers: So that's one. The other is about the changing methods of health care funding in this country that has occurred over time. It's a twenty-year period that I have elected to study. Greater responsibility by government, greater responsibility by employers, the effect of the third-party pay concepts, and a number of funding changes that have occurred. These are the two papers that I'm just finishing now.

Also I have another project, a big assignment. I'm planning to review the health care delivery alternatives in the state of Colorado over a thirty-five year period. I have been here for thirty-five years, and I have been, in some way, involved with every major type of health care delivery in the state, from academic practice to private practice to HMO practice. This monograph will take me about a year and a half to complete. By the end of next year I target it to be in its final draft. It will be the study of about 30 to 35 health care delivery systems in the state.

Chall: Oh really? There are that many?

Reimers: I'll be doing a lot of what you're doing--interviewing the main actors of this scene.

Chall: Yes.

Reimers: Using the machinery, too, because some of these will require a lot of interviewing. Some people will not permit me to tape them, in which case I won't. But I have enough personal contacts with friends that I think most of them will be willing to talk to me about the reasons for failures of certain plans, the problems they are having, and so forth. So that will be a rather sizeable project, and I really don't know that I understand how big a job it will be.

I also have another interest, and that is health care delivery to the aged. Not medical health care of the aged; I don't want to become a doctor skilled in how to take care of old people. I'm interested in how we deliver health care to an increasing part of our population, and do it in a way that this country can afford. Because we're rapidly running out of money. Senior citizens represent a very politically potent minority in this country, and it's one that I belong to now. So I have a lot of interests. And I would like to represent Kaiser in some way, because I think they have a uniquely good system for taking care of elderly people. Care for the elderly will become an ever-increasing problem for the medical profession.

Chall: It has to be looked at by somebody who understands the system and the needs as well.

Groundbreaking, North Denver Clinic, 1982. *Left to right:* Richard Young, M.D.; Gerry Phipps, builder; John Reece, architect; W. L. Reimers, M.D.; Patti Whatley; Tim Wirth, now U.S. Senator; Wayne Moon.

Bill Reimers's retirement banquet, November 1984. *Left to right:* Max Brown, Becky Reimers, Toni Reimers, James Vohs, Carl Berner, W. L. Reimers, Dorris Reimers, Paul Lairson.

Reimers: I think it could be a fun thing to be involved in.

Chall: Well, that sounds as if you're not just going to sit on a shelf, are you? Most of your colleagues don't.

Reimers: I think about my health now, and I have reason to believe that, of course, I'll never be totally well, but I'll be functional.

Chall: If you devote yourself to writing you can handle that, because that's something you can do without too much physical strain.

Reimers: Yes. And I have my own computer that can do my own word processing.

Chall: You're right up to date. That's more than many of us are.

Reimers: Well, I'm not good at it, but I do it.

Chall: You'll learn.

Reimers: I'll learn. And I particularly like that Word Spell, where I can flip the gadget on and have it correct my misspelling.

Chall: You can set up your own program, with your own words in it, medical words.

Reimers: You can add them as you wish, that's right. I spell medical words pretty well.

Chall: It's the others that you've forgotten!

Reimers: It's like when I spell "flat" with two "t"s; something looks funny about that word. But sometimes words just never look right.

Chall: You will have a dictionary at hand.

I think we have a few moments left, and I would like to have you say something else, if you'd like to about your long career as medical director here. How did you look back upon this career that you changed to in mid-life?

Reimers: I look back upon it with a great deal of satisfaction, our failures notwithstanding. I think that's part of the game we're in. I am glad I made the decision I did. I think it allowed me to be at the site of change, and that's really what I expected to do when I made the decision. I knew change was coming, and I wanted to have some ability to alter that change; and that I have had. I have made many friends. I think the program in Colorado has done well and will continue to do well. I think the local leadership across the board is very much on top of things, as far as I'm concerned. I think that they will survive and prosper.

Chall: Good. Well, thank you for your time. It's been a good interview--candid and interesting.

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TAPE GUIDE -- Wilbur L. Reimers, M.D.

APPENDIX

Tribute

The Saint Joseph Hospital Foundation

and the

Colorado Permanente Medical Group

present a

T R I B U T E

to

BILL REIMERS, M.D.

for his contribution to medicine, to surgery,
and to life itself

and

establish

THE ANNUAL BILL REIMERS LECTURESHIP

*****

The Marriott Hotel-City Center
Denver, Colorado
November 21, 1985

BILL REIMERS, M.D.

Dr. Bill Reimers began his surgical career under the tutelage of Dr. Robert Zollinger, then the new Chairman of Surgery at The Ohio State University. In addition to their small town, Midwestern origins, the two men shared an idealism regarding surgical practice and the value of academic discipline.

When Dr. Reimers moved to Denver in 1950, he joined the University of Colorado as a Surgical Fellow under Dr. Henry Swan. Three years later, he launched a successful career in the private practice of general surgery which he continued for seventeen years. During this time, he maintained his clinical professorship in surgery at the University of Colorado with a special interest in head and neck surgery.

At the start of his private practice, he and Doris Atteberry married. D.M. and Bill have three grown children, Stephen, Toni and Becky, all of whom are pursuing succesful professional careers. D.M. has returned to her profession of surgical nursing at the University of Colorado on a part time basis.

The advent of Medicare and Medicaid in the mid 1960's turned Bill's attention to the economics of medical care. He strongly felt the need to preserve conventional medical practice under the threat of socialized medicine. He studied the Kaiser Permanente system in California, and, in 1969, transplanted this program to Denver. Thus began the second half of Bill's career as the Founder and Executive Medical Director of the Colorado Permanente Medical Group. He attended Harvard Business School's Advanced Management Program, and proceeded to shepherd the Permanente Medical Group's growth to 150 physicians and nearly 155,000 members by the time he retired, for medical reasons, at the end of 1984.

In his retirement, Bill remains actively involved in the affairs of the State Medical Society and retains a keen interest in the economic and political trends of health care in this country.

P R O G R A M

Welcome	Sister Mary Andrew President Saint Joseph Hospital
Tribute	Charles T. Jackson, M.D. Colorado Permanente Medical Group
Presentation	Donald W. Parsons, M.D. Colorado Permanente Medical Group
Introduction of Speaker	Donald W. Parsons, M.D.
The Bill Reimers 1985 Lecture "Hormonal Islet Cell Tumors"	Robert M. Zollinger, M.D. Emeritus Professor of Surgery The Ohio State University Columbus, Ohio

THE BILL REIMERS 1985 LECTURER

DR. ROBERT ZOLLINGER is a pioneer American Surgeon who has become a legend in his own time. Born in Millersport, Ohio, he proceeded to Boston for training under Drs. Harvey Cushing and Elliot Cutler. He joined the academic ranks at Harvard Medical School and the Peter Bent Brigham Hospital. During World War II, he commanded the Fifth General Hospital in Europe and received many decorations.

At a youthful age of 42, he assumed the Chair of the Department of Surgery at The Ohio State University in Columbus, Ohio. His contributions since have been of historic proportions. Not only has he authored 350 publications, including his famous Surgical Atlas, but he has introduced the fascinating field of endocrine surgery of the pancreas. The Zollinger-Ellison syndrome bears his name.

Dr. Zollinger has received worldwide acclaim. He has served as the President of the American College of Surgeons, the American Surgical Association, the Society of University Surgeons, the Central Surgical Association and several other prestigious organizations. He has chaired the American Board of Surgery, serves as Editor-in-Chief of the American Journal of Surgery and holds several other editorial board appointments. He has been honored by four academic medical societies with honorary membership. He has received many other recognitiions for his contributions to the art and science of medicine, including the coveted Gold Headed Cane Award and the American Medical Association Scheen Award in 1977 given to "The Outstanding Doctor of Medical Science in the United States."

Not the least of Dr. Zollinger's accomplishments has been the training of a legion of surgeons spread throughout the United States. Dr. Bill Reimers is one of those surgeons. His career reflects Dr. Zollinger's values of integrity, academic discipline and the striving for excellence and innovation.

Saint Joseph Hospital, Denver, Colorado

MEDICAL

STAFFTER

Vol. 25, No. 12, December, 1984

Dr. Reimers Retires From Permanente

Bill Reimers, M.D., has retired after 15 years as President and Executive Medical Director of the Colorado Permanente Medical Group. He was one of the three founding members of this group which was inaugurated in 1969.

Reimers joined the Medical Staff of Saint Joseph Hospital in 1953 as a member of the Department of Surgery. He was in private practice in Denver until 1969 when he elected to accept the challenge of pioneering an association of physicians of a prepaid medical plan with the physicians of the Saint Joseph Medical Staff. At that time Saint Joseph Medical Staff represented many solo practitioners, small group practices and a large group practice, all in fee-for-service medicine.

Today we are familiar with such concepts as HMO's, PPO's and IPA's as we continue to be introduced to new options within the practice of medicine. In 1969, however, the idea of a Medical Staff being able to assimilate diverse groups while maintaining the unity required for all to work together for the good of all the patients was a novel idea.

Likewise the concept of a large prepaid medical plan utilizing the services of community hospitals rather than owning and managing their own was unique within the Kaiser Permanente system. The Saint Joseph Hospital Medical Staff had a long tradition of excellence and vision. Dr. William Covode, a former President of Saint Joseph Medical Staff, was President of the Colorado Medical Society in 1969. In an interview at the time of his election, Dr. Covode stated, "If Kaiser-Permanente comes to Denver it will give us an opportunity to see at close hand another type of delivery of health care."

Bill Reimers wrote in the Denver Medical Bulletin in June, 1969, "The Permanente physician is, of course, a member of a team of physicians who have committed themselves to a common goal — quality medical care at a reasonable cost." He further stated, "As with any other physician in the Denver area, the doctor who associates himself with the Permanente group eventually must be judged by how well he discharges his responsibility to his patients, to his profession, to his hospital and to his community."

Perhaps this as much as anything else exemplifies Bill Reimers' philosophy of providing medical care. Throughout the past fifteen years his primary objective has been quality of care provided by a first class organization in first class facilities.

Throughout the years the Colorado Permanente Medical Group physicians have worked side-by-side with other Saint Joseph Hospital distinguished Medical Staff members to deliver the excellence of care for which Saint Joseph Hospital is noted. The entire Medical Staff has maintained the goal of quality patient care as a unifying objective. The Staff has affected successful working relationships and integration of types of practice that were unique in the 1970's. Bill Reimers not only wholeheartedly believed in such a relationship, he diligently worked to continually improve it.

Although Bill Reimers is retiring, he will continue to contribute to the Hospital and all of our Medical Staff. He is anxious to continue working with the committee and educational structure of organized medicine and our Hospital.

As a former President of the Medical Staff and member of the Board of Directors of Saint Joseph Hospital, Dr. Ted Sadler notes that Dr. Reimers has been most effective during these past fifteen years in integrating change and solidifying the partnership with our Hospital. A partnership which shares common goals will continue to grow.

Carl E. Heaton, M.D., current President of our Medical Staff expressed the following in a personal communication to Dr. Reimers. "Your farsightedness, manifesting itself by your involvement with the Kaiser Permanente Medical System, is well recognized, and the wisdom thereof is obvious. You have consistently surrounded yourself with a health care staff that is dedicated, stimulating and contributing nothing but the best of themselves to Saint Joseph Hospital as you, yourself, also had. I am particularly appreciative and aware of the impact of the involvement of the physicians on your staff in the process of teaching physicians-in-training, as well as those on the Medical Staff in the care of patients. This no doubt reflects your own personal attitude toward involvement of a Medical Staff of a hospital in this process. That involvement has been a major contribution to the teaching program at Saint Joseph Hospital."

The Saint Joseph Hospital and Colorado Permanente Medical Group staff share the common goals of providing quality patient care that is cost effective. This will continue to be the goal as Dr. Toby Cole now works with us in Dr. Reimers' stead.

PHYSICIAN ORIENTATION

April 12, 1985
W. L. Reimers, M.D.

If I were not already well aware that I am no longer the Medical Director of this region I certainly would be reminded of it this a.m. by my placement on today's agenda. If I were still the EMD there would be no way that I would consent to follow Cec Cutting on this program. Dr. Cutting has always been a tough act to follow, a painful experience that I well remember. Despite this, I regard him as a close friend, a mentor and hero -- one whom I still try to emulate even in my retirement. As a medical elder statesman, Cec Cutting has no peer. One is not born, nor is he formally trained, to be a Regional Medical Director. He learns on the job and, especially from other people. In this sense, no person has influenced my philosophy of the job, nor my performance in the job more than has Cec Cutting -- even though, as you will recall, the Colorado Region was sponsored by Southern California, not Northern California. Dr. Cutting has always been very kind to this region, as he is again by being with us today.

As for our beginnings in Colorado. Many of you were present at my retirement dinner in early November At that time Jim Vohs set the record straight as to how I became involved with Kaiser-Permanente. He recalled that it was I who sought out K-P leaders to explore how I might fit into their plans. My fame was not so far-reaching that they came pounding on my door. This first contact in Los Angeles was more than a year prior to our formal opening of the region in July of

1969. I was given the mission to explore quietly the possibilities of putting together the initial core of a medical group from proven people already practicing in Denver. This proved to be difficult and made worse by the secrecy required. We planned to start with the four major specialties: Internal Medicine, Surgery, OB/Gyn, and Pediatrics. I offered the position of the first OB/Gyn to three local practitioners before Dave Blanchet joined me and to four Denver pediatricians before Robb Howard accepted. Neither made his commitment known publicly for another six months and each retained his option to back out, which Dr. Blanchet did within a year. Fortunately Robb stuck it out and informed his private patients of his decision. During this time I was busy making speeches to hospital staffs, specialty groups and medical societies extolling the virtues of prepaid group practice, something that I had never done! My surgical practice collapsed, as I had expected. Despite vigorous efforts we were unable to convince a local internist to head up this important department until well after our opening day.

In continuing my assignment this a.m. to review the history of CPMG, I'm now going to change techniques. Rather than to continue with narrative chronicle of the years involved I will instead give to you some snapshots of then and now, and scattered ones in-between, hoping to give you an appreciation of a period of constant change. After than, with the advantage of hindsight, I will share with you my opinion of some of the things we did right and others in which, I think, we could have done better.

First, the matter of change. Because no single event, or year, seems especially dramatic, one has to step back from the individual episodes to appreciate the undeniable trends that were occurring in the health care field, and the part that we played on that stage. This slow transformation suggests the concept of "metamorphosis" of living organisms. I like this analogy. I am enamored by the idea that at the beginning CPMG was a slow, sluggish, even ugly caterpillar which eventually became an exquisitely beautiful butterfly. The dictionary uses a different example of metamorphosis: the transformation of a tadpole into a frog or toad. Somewhat less exotic, to be sure, but so be it! This latter analogy may be more fitting anyway. Perhaps after 15 years we are more like a toad than a butterfly? At times I have felt like this.

A. MORPHOLOGY OF CPMG (1969 thru 1984):

1. Genesis:

To "start from scratch" was a deliberate decision of the Kai-Perm Committee in planning the Colorado Region. It was impractical to think of giving day-to-day support from any existing region, the nearest of which was over 1,000 miles away. Also, it was not known whether the K-P concept could survive without its own hospital.

2. Support:

Both the Health Plan and the Medical Group made an open promise to the community that we would use local talent and existing facilities to the greatest extent possible. This policy helped greatly, through the years, to defuse some of the suspicion and hostility of the medical and hospital community toward our program. Outside professional and hospital costs, even today, make up a sizeable fraction of our budget. In 1984 $6.7M was paid to outside F-F-S physicians and $28.3M to local hospitals.

3. Growth:

Year	Year-End Membership*	Number of Physicians
1970	13,000	14
1971	23,000	24
1972	40,000	35
1973	50,000	50
1974	60,000	62
1975	65,000	70
1976	76,000	61
1977	91,000	70
1978	102,000	90
1979	108,000	100
1980	116,000	99
1981	124,000	110
1982	135,000	121
1983	148,000	136
1984	157,000	160

*(nearest 500)

Notes:

a. One M.D. per 1,000 members is planned. Significant discrepancies from this ratio occur from variations from membership forecast sand physician recruitment difficulties.

b. Because of the lead-times necessary in the building of clinic space it is difficult to fine-tune this function. However, by year-end 1984 we had about 400,000 sq. ft. available, an aggregate of nearly 10 acres!

4. Organizational Form:

CPMG started as the first professional corporation approved under a new state law in 1969. In 1973 we became a partnership and reverted back to a corporation in 1981. Suffice it must for now to say that we underwent this pendulum-swing for tax and personal liability reasons, real or perceived. All other PMGs are now incorporated, or are in the process of becoming so.

5. Competition:

A major change, through the years, has been the professional climate in which CPMG has operated. At the start we were severely criticized but, also, had little competition in our mode of practice. At that time we were the "only game in town" and, like a floating crap-game, made to look disrespectable. There is no question that our presence in the city greatly stimulated the formation

of competitive forms of medical care. And when we finally became accepted by the public and "legitimate" in the eyes of our medical colleagues they panicked to get a "piece of the action." Thus, it seems that in order to achieve respectability we have had to share our unique place in the market with many competitive forms of care: Comprecare, United Health, Colorado HMO, Peak Health and other still emerging types and combinations of HMOs, IPAs, PPOs, etc. This has been especially so since the passage of the HMO Act of 1973.

B. LIVING WITH CHANGE

One would think that managing a region caring for 150,000 people would necessitate daily, new, exciting decisions. The fact is that such one-shot decisions, ones that stay decided, are pretty rare in this business. Far more common are decisions dealing with chronically recurring problems often resulting in temporary solutions. In other words, many of the problems do not stay solved and today's solutions do not necessarily work next week, or next month. Here is a list of such generic concerns that seem always to be with us. This is, by no means, a complete list. Without any significant discussion of any let met list for you 10 worries that probably took up 95% of my time as the EMD:

1. Interface with worried, suspicious, sometimes hostile F-F-S physicians.

2. How to work in someone else's hospital.

3. Recruitment of quality physicians.

4. Control of outside medical costs.

5. Internalization of specialty services, when? how?

6. Member satisfaction, especially accessibility.

7. Impersonal care/rudeness.

8. Provider satisfaction.

9. Turnover of Regional Managers (5) and RMFMs (5).

10. Growth/competition/cost to member

C. HINDSIGHT

For me an interesting exercise is to look back over our trail and to make evaluations about whether we like what we see. Hindsight, as with foresight, is in the eyes of the beholder -- so for the next few minutes you will see only what I see. Let's deal with my regrets first because they are fewer in number and much more subject to debate than what I consider to have been our successful achievements.

1. Regrets (?)

   a. Should a hospital have been built sooner? A good case can be made that we should have taken advantage of a window of opportunity in the mid-70's before Certificate of Need restrictions came into effect. However, several advantages that, incidentally, may have more significance to the medical staff than to the health plan:

      -- During our earlier years we were "100% financed" and capital was severely limited. We chose to build multiple handsome outpatient facilities rather than to add beds to an already over-built hospital situation.

      -- Working in the best hospitals in the city greatly eased our recruitment of physicians. Tours of SJH and DCH convinced many recruits that we were indeed "going first class."

      -- A prolonged experience at SJH and DCH has produced a climate of professional excellence among our staff that, hopefully, will be transplanted into our hospital when it is built.

      -- 15 years at SJH and DCH has bought us time for the membership to grow to a sufficient size to justify building a high quality, near full-service hospital.

      -- Working with the staffs of other hospitals has prevented isolation of our staff from the rest of organized medicine. First-hand knowledge of the caliber of our people by outside physicians has been an important ingredient of CPMG's professional image, one that has no equal in this state.

   b. Ambiguous M.D. work requirements? Because of varying daily schedules of different individuals and specialties, early on we allowed work requirements to be very flexible and very much up to the judgment of the doctors themselves and to their Chiefs and PICs. However reasonable this seemed at the time, this ambiguity has led to a widespread perception of inequity among physicians. In retrospect, much of this confusion could have been avoided with clearer understanding of work requirements at time of hire of all physicians. To attempt to make changes later has been extremely difficult, as evidenced by the amount of ill-will generated by the Work-Week Committee a couple of years ago. All in all, this is a legacy for which I accept full responsibility but regret leaving unsolved with the Group.

c. Dependence upon physician surrogates? What is the appropriate number or ratio of physician-extenders? I am personally uneasy about it but who knows the answers? I feel this issue has special significance for this region because we make greater use of these providers than any other region for reasons that are not all that clear -- considering the likelihood of a physician glut in this country. Many predict a significant drop in physician incomes during the next 10 years because of the massive infusion of these less well trained providers into the system.

d. Is the CPMG Board too "political" by having 6 out of 7 voting positions filled by election? I think so and think there should be a better balance between management and elected positions. This may not yet have been a problem but I predict that someday it may cause an instability of the governing body that will take considerable political courage to correct. Other regions have avoided this vulnerability through their original By-Laws. I regret that we did not.

e. The issue of "merit" pay? Should good doctors be better compensated than bad ones? I think so and so did 2/3 of the Medical Group when they were polled on this issue in 1983. Again, I regret not having had the foresight to have instituted "merit pay" in 1969, and not having found a workable formula to achieve it in 1983.

f. Geographic expansion? I think that by this time we probably should have made a commitment to Boulder, or to Fort Collins, or elsewhere in the state. However, this is the type of decision that requires full concurrence of the Health Plan. As with most controversial questions, there are many good reasons why such expansion may have been ill-advised. One such reason is the financial priority of the region, of which I spoke earlier.

g. Sagging growth rate? Earlier figures indicated a rather dramatic accumulative growth over a 15-year period. When one considers the annual percentage growth, however, a somewhat different picture emerges. Our growth is definitely slowing. I do not believe that bigger is better but I feel that consistent growth is vital to the health of the Medical Group. Many of our goals cannot be reached if we do not grow. To what extent is the sagging growth the responsibility of CPMG? Is it entirely the fault of the Health Plan if members leave us? It is a legitimate question to ask. At any rate, for this discussion, I would have preferred leaving the Group at a time of more robust growth.

I have just reviewed seven areas that have elements of regret for me at the end of my tenure. Each of them is equivocal and debatable. In some instances only the future will determine the relative merits of these issues.

2. Accomplishments:

I am still using my rear-vision mirror, looking back down the steep trail we have been climbing for the past 15 years. Despite the few misgivings I mentioned earlier, I'm extremely proud of this Medical Group and its achievements (as you should be) and here are some of the reasons why. I will list 12 but discuss only three:

a. Commitment to "go first class":

What Mr. Vohs did not comment on at my retirement dinner was a personal pledge that we made to each other at our very first meeting. We agreed that because the program was virtually unknown in Colorado, Denver would be a tough nut to crack, both professionally and in the marketplace, unless our product was above reproach in all respects. We agreed to "go first class" and avoid, at all costs, an image of a low-cost, low-quality program. This resulted in selecting the finest hospitals and the highest quality providers we could find. The Health Plan never once flinched from that promise, even though it resulted in five years of time and $5 million of debt before we were in the "black" financially. "On the cheap" it could have been done quicker and with much less red ink. I'm pleased that we agreed to "take the high road" despite the financial uncertainties of those early days.

b. Survival, growth and solvency without a hospital:

c. Integration into the medical community:

This is an area that should be of great personal pride to us all. We have been active participants on hospital staffs, in specialty societies and medical societies since our first day as a group. Three of our physicians have been Chiefs of Service; three have served on the Executive Committee and two have been named the outstanding teacher of the year -- all at SJH. At least four have been presidents of specialty societies. Bob Lederer is in his second term on the State Board of Medical Examiners. Many have served as Delegates to CMS and probably the most illustrious achievement of all is that Don Parsons will assume the duties of President of DMS this fall. In addition to all of this a number of CPMG physicians are active in teaching roles at the Medical

School. These many diverse activities, plus the professional, teaching and administrative responsibilities within the Group, require a great deal of off-duty time and dedication. But how else does one every gain and retain the respect of his peers? He does it the "old-fashioned way -- he works hard and he earns it!" All of the above should make us proud of ourselves and our colleagues.

d. Quality medical group:

e. Quality outpatient facilities:

f. Quality hospitalization:

g. Practice Review/Staffing Model (PRISM):

h. Physician administrative training:

Dr. Cutting and his colleagues, in earlier years, fought hard and won a major concession from Health Plan for the physician groups to be equal partners in the administration of the program -- wherever it exists. I have preached for years that to be up to this task the physician leaders should be as serious about developing administrative skills as professional ones. The EMD, and the EMD-elect, at the time they held these titles, attended advanced management programs at Harvard and Stanford, respectively. About 10 doctors have attended the split fall-spring courses at Stanford and PICs and Board members regularly attend off-site MOD sessions twice a year. Moreover, an in-house training program, involving even more physicians with line responsibility, will finally come into being this year. Again, this is an area of CPMG priority and performance about which I personally am very proud.

i. Hospital Certificate of Need and plans:

j. Competitive physician salaries:

k. "Corridor" incentive-pay plan:

l. Retirement plans (PPRP, Cash or Deferred):

Well, there you have it! In a somewhat jumbled manner I've attempted to give you some glimpses of our past through my eyes. Are these views distorted? Probably! Are they biased? Certainly! Do

they lack humility? I suppose so! Are they patriarchal? Very likely! Are they honest? I certainly hope that you think so!

You may now understand why I prefer to think of our Medical Group today more as a butterfly than a toad. I believe your future will be beautiful and exciting. Robb Howard said it well in the last issue of Colorado's RECORD with these words: "CPMG is on the verge of blossoming." So be it!

I wish you well. Especially, my best wishes go to your new leadership team: Drs. Cole and Lawrence. They are very well equipped for their jobs but they will need your help, just as I did. Please give to them the kind of loyalty and support that you have so generously given to me in the past. Godspeed, and thank you for the privilege of sharing my thoughts with you.

WLR

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PERSONAL:

Born:	26 February 1919
Spouse:	Dorris (Atteberry)
Children:	Stephen (2-3-56), Toni (3-4-57), Rebecca (7-17-60)

TRAINING:

1932-36	High School, Big Springs, NE
1936-39	University of Nebraska, Lincoln, NE
1939-43	M.D., University of Nebraska College of Medicine, Omaha, NE
1943	Internship, Ohio State University Hospital, Columbus, OH
1943-45	Battalion Surgeon; Major, U.S. Army Medical Corps; WW II
1945-50	Surgical Residency, Ohio State University Hospital (4 yrs)
1950-52	Surgical Residency/Instructor in Surgery, University of Colorado (2 yrs)
1973-74	Advanced Management Program (14 wks), Harvard Business School, Boston, MA

MEDICAL PRACTICE:

1953-69	Private surgical practice, Denver, CO
1969-72	Chief of Surgery, Permanente Medical Group, Denver, CO

ADMINISTRATION:

1970-1984	Executive Medical Director, Colorado Permanente Medical Group

BIBLIOGRAPHY:

Several published articles in local medical journals and numerous presentations in recent years dealing with health care delivery, i.e., prepaid group practice, HMOs, Kaiser-Permanente, etc. Currently doing background research preparatory to a monograph on Health Care Delivery Alternatives in Colorado, 1950-85.

HONORS:

1952	Diplomate, American Board of Surgery
1953 to present	Assistant Clinical Professor, Department of Surgery, University of Colorado
1958	Fellow, American College of Surgeons
1964	President, Denver Academy of Surgery
1985	Establishment of the Reimers Lectureship 10-1-85

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INDEX— Wilbur L. Reimers, M.D.*

*Unless otherwise specified all place names are California. KPMCP refers to Kaiser Permanente Medical Care Program.

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Graduated from Reed College in 1942 with a B.A. degree, and from the State University of Iowa in 1943 with an M.A. degree in Political Science.

Wage Rate Analyst with the Twelfth Regional War Labor Board, 1943-1945, specializing in agriculture and services. Research and writing in the New York public relations firm of Edward L. Bernays, 1946-1947, and research and statistics for the Oakland Area Community Chest and Council of Social Agencies 1948-1951.

Active in community affairs as a director and past president of the League of Women Voters of the Hayward Area specializing in state and local government; on county-wide committees in the field of mental health; on election campaign committees for school tax and bond measures, and candidates for school board and state legislature.

Employed in 1967 by the Regional Oral History Office interviewing in fields of agriculture and water resources. Project director, Suffragists Project, California Women Political Leaders Project, and Land-Use Planning Project, and the Kaiser Permanente Medical Care Program Project.